# A Phenomenological Analysis of Women's Choices, Expectations and Experiences when Intending to Give Birth in a Birth Centre

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**Abstract:**

The aim of this study was to explore the factors that influenced women to choose care in a birth centre in the South Wales Valleys, and to ascertain their expectations and experiences of care in the antenatal period and during labour.

The possibility of complications arising during normal pregnancy is a well-known phenomenon, leading to a woman's care being transferred from a midwife to an obstetrician. For women intending to give birth in the birth centre, this also meant having care transferred to the District General Hospital eight miles distant. Experiences of those women who had care transferred were of a particular interest. Even though transfer is a common occurrence, little research exploring the effects of this from the woman's perspective has been carried out.

The study was qualitative, using thematic analysis based on Gadamerian phenomenological principles. Semi-structured interviews were carried out with a purposeful sample of twenty women who described their antenatal experiences. Five of the women were later transferred from midwifery-led to obstetric-led care in the obstetric unit, with three of the transfers occurring during labour. A second interview was held with these five women to explore their experiences further.

Key findings indicate that women choose the birth centre for its friendly, welcoming environment and woman-centred midwifery care. The influence and importance of family around the time of birth was a notable feature. Women transferred in labour subsequently experienced a different model of care, which for one woman meant that she remained empowered to make choices and decisions about her labour, whilst two other women felt some aspects of care to be mechanistic and impersonal.

Recommendations from the study include further, larger scale research into women's experiences of transfer. Areas where specific guidance and education may be beneficial are suggested, to give a better understanding of those aspects of transfer that might affect women.

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# Part One – Establishing The Study

## Chapter One: Introduction

Birth is part of the human life cycle, and although there are cultural differences in how and where birth is conducted, its significance is acknowledged in almost all societies (Raphael-Leff, 2001). Birth is inextricably linked to gender; women give birth, and this confers a particular role within society for women, based on the culture in which they live. The role of '*motherhood*' is grounded in historical and societal influences, and an understanding of women's cultural identities enables midwives to give support through the transition from woman to mother (Davies, 2000). However, midwives' views of the world are also shaped by their own backgrounds. Gaining insight into another culture requires contemplation of how our own and other communities are formed. Social constructionism is a method of enquiry that can be used to allow us to acknowledge and look beyond our own experience, as Gergen (1999: 101) suggests:

> *"By reflecting critically on our taken-for-granted worlds, and the way in our lives are affected by these constructions, we may be freed to consider alternatives."*

In this way, midwives can be aware of the collective beliefs and values about childbearing that give women the opportunity to make sense of their childbirth experiences, a necessary part of successful motherhood (Callister, 1995). It has been acknowledged that a poor and unresolved birth experience can lead to the psychological ill health of the mother (Raphael-Leff, 2001), and in contemporary western societies, it is mostly women who have the responsibility for the organisation and delivery of childcare (Bilton *et al*, 2002). It would therefore seem desirable for the wellbeing of both women and children to provide maternity care that promotes a positive birth experience.

Current health policy in the United Kingdom (UK), seen, for example, in the standards set by National Service Frameworks for Children, Young People and Maternity Services (DoH, 2004, WAG, 2006a[1]) emphasises the need to provide

[1] Since Devolution in 1997, developing and implementing health policy in Wales is the responsibility of the Welsh Assembly Government [http://www.direct.gov.uk]. Although standards such as the National Service Frameworks are often similar, Welsh policies and standards reflect the health needs of Wales, rather than the UK in general.

women with care which enhances their experiences of birth and begins the process of promoting the health of children and young people. The challenges outlined for healthcare providers are set out in the in the NSF framework (WAG, 2006a: 25):

> *"Pregnancy and childbirth are natural events but also have a great social and emotional significance, particularly for those who are experiencing this for the first time. The prospect of transition into parenthood can bring great joy and excitement but also brings anxiety about the birth process and the responsibilities that parenthood brings. The challenge for health care providers is to minimise risks for mother and baby, ensure that the experience of pregnancy and childbirth is a satisfying one, and support the family in adapting to the changes needed to love and nurture a new member of the family"*

In this way, it is hoped to bring a long-term improvement to the health of people in Wales, reported in the Cabinet Statement, which introduces the National Service Framework (WAG, 2006a: i)

> *The National Service Framework (NSF) sets out the quality of services that children, young people and their families have a right to expect and receive. There is nothing that is more important to Wales' future than our children".*

Although the NSF sets out standards, rather than policies for healthcare, they are intended as a basis for policy development and service planning, with an emphasis on setting definitions of quality that can be monitored (WAG, 2006a). The standards include those relating to child and family centred services, and access to, and quality of, services. A number of key actions are identified that are necessary to achieve each standard, together with the responsible organisation.

Policy which puts women and their families at the forefront of service planning is a recent innovation, as health policy in the past has concentrated on medical aspects of maternity care, rather than on issues important to women (Garcia *et al*, 1990). This can be seen in the way that the inception of the NHS in 1948 led to childbirth becoming increasingly medicalised as women made use of free health care for the first time. A belief in the safety of hospital birth began to influence the development of health policy to support this stance (Kent, 2000). Birth changed from being a social, family occasion to a medical event (Henley-Einion, 2003). From the 1970s onwards, women, unhappy with the mechanistic and interventionist approach to care which they encountered, began to tell of their dissatisfaction and the effects that this had on them and their families (Beech and Phipps, 2004).

Consumer pressure in the UK led to an all-party House of Commons review of maternity services, published as the *Winterton Report*, (HMSO, 1992). This report concluded that women and babies did not receive care that met their needs, and also challenged the accepted view of the safety of hospital births. The Government responded by establishing an Expert Maternity Group to make recommendations for future maternity services (Manero *et al,* 2003). This Expert Maternity Group report recognised that to improve birth experiences, women ought to have involvement in the planning, organisation and provision of their maternity care, introducing the element of choice in the type of care they could receive. *'Changing Childbirth'* (DoH, 1993: 18) states:

> *"The woman should be the focus of maternity care. She should be able to feel that she is in control of what is happening to her and able to make decisions about her care, based on her needs, having discussed matters fully with the professional involved."*

Choice, continuity and control were the three underlying principles outlined in the report, based on the views of what women wanted from their care. One way of achieving the element of choice and improving women's participation in their care was for local maternity services to provide an option of midwifery-led care for women with uncomplicated pregnancies. As a result of this and to provide a pragmatic solution to the proposed closure of a local maternity unit, a birth centre (the first in Wales) opened in 1995. The birth centre was a stand-alone unit that offered this choice of care to women from a South Wales Valley (referred to in this study as Cwm Fechan, a fictitious name) who met the health criteria used to screen women for their suitability for midwifery-led, rather than obstetric-led care (see appendix 1). Women who later developed complications during pregnancy or labour were transferred to the care of an obstetrician in the District General Hospital (DGH) some eight miles distant. Although there was some initial scepticism from local GPs and obstetricians about the demand for such a service, the birth centre became a popular local choice for women, and each year since its opening has seen a rise in the numbers of women who want their maternity care there. Currently, two-thirds of pregnant women in the locality make the birth centre their first choice for maternity care, although pregnancy complications mean that approximately half of these women will require transfer to the care of an obstetrician (see appendix 2).

Prior to this study, I was aware that a number of women who were transferred voiced their dissatisfaction with this process, usually to their midwife on their return home, but occasionally as an informal complaint to the manager of the unit. Complaints tended to be non-specific, often explained away by midwives and obstetricians as being due to disappointment, or being a result of the local feelings about the loss of obstetric services in Cwm Fechan. On reflection however, this seemed a simplistic view, and I speculated whether further investigation would reveal that women's concerns might have been associated with the physical transfer, the outcome of the birth, the overall birth experience or other factors.

As a midwife working in the birth centre, and as a mother myself, I was intrigued by the experiences of these women. I too had been transferred from one hospital to another when having my first baby, and although the circumstances of my transfer were different to these women, their experiences nevertheless filled me with a great curiosity (see also section 5.12, Researcher Reflexivity). When, several years later, I became a midwife manager in the birth centre, women's experiences took on a different level of meaning. To be an effective manager, I needed to ensure that the care provided there met the needs of women. I intended to achieve this by working together with other health professionals to ensure that women's needs were being met, particularly after transfer. This was succinctly summarised by Carlson (2005: 59):

> *"As a good manager the midwife needs to be a team player, with the ability to work across professional boundaries, and to break down profession-client boundaries where appropriate".*

Little was known of women's experiences when care was transferred, with only two studies known to the author which were carried out in the UK exploring this aspect (Walker *et al*, 1995 and Creasy, 1997). These two studies are discussed in more detail in chapter two. Neither study addressed the specific issue of women's experiences of transfer when they had planned to give birth in a birth centre, and had received maternity care in this way. The study by Walker *et al*, (1995) included women who had received any aspect of care in a midwifery-led unit, rather than women who had specifically chosen to birth there, and Creasy, (1997) carried out her study in a midwifery-led unit sited within the obstetric unit in the DGH, requiring no transfer between hospitals.

This suggested an opportunity to carry out a research project that would contribute a different aspect to the existing knowledge about the phenomenon of transfer. Initially, the research was intended to explore women's experiences when they had care transferred from birth centre to DGH during labour. However, as the study evolved from an idea to a research project, the aims of the research also expanded and developed into a desire to explore what influenced women's decisions to choose the birth centre for their births, what they expected and experienced from care in the birth centre and when they had care transferred. The aims of the study became defined as:

- To identify why women wanted midwifery-led care in a birth centre;
- To elicit women's expectations in the antenatal period and for labour and to explore their experiences of care;
- To conduct an in-depth study of the experiences of women who had a transfer of care from the Birth Centre to the nearby obstetric unit in late pregnancy or during labour.

To meet the aims of the study, a qualitative approach was chosen, using thematic analysis. Phenomenological principles were adopted to fulfil the objective of exploring the world of the participants through their experiences and perceptions of events. This enabled the interpretation of these in a meaningful way to give an understanding of the experiences of women. Although phenomenology governed the structure of the research process, the theoretical influence of social constructionism provided another aspect that contributed to the understanding of the participant's experiences. Looking at the history and culture of the area and how and why the birth centre was developed enabled factors that were of social significance to the women to be identified and incorporated into the findings of the research.

### 1.1 Structure of the Thesis

The study is divided into two parts. Part one describes the course that was followed to undertake the research process, whilst part two presents the findings of the study, with a discussion of the main themes that arose, followed by the conclusions and recommendations. The two parts of the study contain nine chapters, outlined below.

Chapter two presents the preliminary literature review, undertaken to explore broad questions about what was known of women's experiences of transfer, and what factors influenced their experiences and expectations of childbirth. This initial review was important in refining the aims of the study, but avoided pre-empting the findings, in keeping with the phenomenological method (Streubert and Carpenter, 1999).

Chapter three discusses the theoretical influences for the study, detailing the reasons for choosing social constructionism as a stance from which to approach the study, and explaining the contribution this made. Chapter four describes the background information that puts the study in context, detailing the industrial background of the valley and the effects of this on the communities who live there. These two chapters explore the ways in which historical, social and cultural factors have influenced life in Cwm Fechan, and the attitudes of women, families, midwives and doctors towards childbirth.

Chapter five discusses the methods and design of the research, exploring why a qualitative approach was chosen and explaining why the choice for a thematic analysis was made. Several studies where thematic analysis was used are discussed, and how they have been useful in establishing the research process outlined.

Chapter six explains how the research was conducted, from choosing the sample of women, carrying out the interview process and gathering and analysing the data. The use of a computer software programme to aid initial data analysis is discussed, and the reasons for discontinuing its use at that stage debated.

Chapter seven presents the findings of the study, including the socio-demographic information of participants. Limitations to the study are discussed. Themes arising from the data are introduced, supported by quotations from the participants. Analysis and discussion of each theme then follows, supported by extant literature. Finally, the theoretical influences are related to the findings of the study.

Chapter eight presents conclusions and recommendations for practice and further research, and notes the limitations of the study.

Finally, chapter nine relates personal reflections on the study, so completing the thesis.

## Chapter Two: Preliminary Literature Review.

Several complaints from women following transfer from midwife-led to obstetric-led care initiated a literature search being undertaken to discover what was known about women's experiences of this aspect in the UK. Of special interest were the experiences of women transferred in labour, as anecdotal evidence suggested this was a prominent factor where women had been dissatisfied with care. The original literature search, undertaken in 2001, indicated that few studies had been carried out in the UK on this particular aspect; in fact there were only two – Walker *et al*, (1995) and Creasy, (1997). Therefore it appeared that further exploration of this topic was necessary as there was clearly a gap in knowledge, and it was decided to commence this study properly in 2002. Little was known about women's experiences of transfer from midwifery to obstetric-led care particularly in relation to being transferred from a stand-alone birth centre. An exploratory method of research was therefore appropriate, (Brink and Wood, 1989). A qualitative method of enquiry was favoured, although the actual method had not been decided upon at that stage. Using a qualitative research paradigm was congruent with the original aim of the study: to explore women's experiences of transfer of care.

The study design and research methods are discussed in detail in chapter five, but it is useful here to clarify the process and purpose of the preliminary literature review. A literature search is performed in order to identify sources detailing information about the topic in question, and is described as a '*critical step in the research process'* (Burns and Grove, 2005:117). Knowing what subjects have already been studied in detail may circumvent the need for further research in that particular area or, as was the case in this study, may help to focus the research question (Holloway and Wheeler, 2002). Where further research is indicated, the literature is critically appraised, and a written review produced. The issue of when the literature review should be carried out however, is the subject of debate: there is a danger that the findings from related studies may influence the researcher, for example in affecting the interpretation of qualitative research data (Morse, 1994; Woolcott, 2002). Given that this study was to follow a qualitative research paradigm, it was inadvisable to perform an extensive literature review at this stage (Streubert and Carpenter, 1999; Holloway and Wheeler, 2002). A pragmatic solution to this dilemma was to review

the literature regarding transfer of care, together with any salient features identified in the review, as a means of refining the aims of the research.

## 2.1 Chronology

During 2001, and again at the end of 2002, a search of available electronic databases including *MIDIRS, Cochrane, Healthstar, CINAHL* and *Medline* were made using combined keywords such as women; midwifery-led care; transfer; expectations; experiences and birth as the search terms for articles published in English. Different combinations of terms were used until meaningful search results were obtained. Hand searching of journals was also carried out for publications spanning the previous ten years. Of the many articles that were available, those from peer-reviewed journals were chosen as they maintained a widely accepted standard for publication. Principal journals searched were *Birth, Midwifery, British Journal of Midwifery, Journal of Advanced Nursing, Social Science and Medicine, Midwives* and *MIDIRS*. As midwifery-led care was developing in the UK from 1992 onwards, the date parameters were set from that date to when the search was conducted. Searches, limited to UK studies in 2001, were widened to include countries with similar, although not directly comparable systems of care. It was decided to include only those articles in which midwives (or equivalent) provided care for women in labour and during birth. Midwifery care is a prominent part of maternity service care in Sweden, Denmark and the Netherlands, although the Netherlands also offers the opportunity for birth at home that is not available in the other two countries (McKay, 1993). Iceland also has a strong tradition of midwifery care, and all the above countries belong to the Nordic Midwives Association, an organisation which shares experiences in the organisation of midwifery care, education and practice (Bondo *et al*, 2004). Although health care differs from country to country, there is some common ground to be found in the role and status of midwives, and of midwifery care, meaning that the publications are relevant. This became increasingly important during the course of the review of literature, where studies also included those carried out in parts of Australia where midwifery-led care is a prominent feature.

The preliminary literature review aimed to explore women's experiences of transfer. In total, four studies had been identified: Walker et al, 1995; Creasy, 1998; Weigers

*et al*, 1998 and Wilklund *et al*, 2002: see section 2.3). Salient factors that might affect women's experiences during pregnancy were found in these four studies that were then explored further. These were women's expectations for labour, and how these affected their experiences (sections 2.4 and 2.5). They included aspects of pain relief, relationships with midwives and other staff, whether women felt adequately prepared for labour and birth, and the concept of knowledge and control. Women's views of the birth environment were also reviewed (section 2.6) as these offered insight into different elements that might influence how the women in this study chose their care.

Further searches were carried out on these topics during data analysis (2005), and again during the writing of the thesis (2008) to see if new research had been carried out. A report by the National Perinatal Epidemiology (NPEU) Unit in Oxford was identified in 2005, (Stewart *et al*, 2004) which suggested that a large-scale study to assess the psychosocial experiences of women who use birth centres, including an in-depth study of women who are transferred should be undertaken, to address the lack of existing research. This is currently in progress (NPEU 2008 [Internet] http://www.npeu.ox.ac.uk/birthplace). Following the preliminary literature review, no further searches were undertaken until after data collection was complete, to avoid pre-empting the findings of the study. When data analysis began in 2005, the literature review recommenced following the identification themes that arose from the research, and is presented in relation to the findings of the study in chapter 7. This process continued throughout the period of data analysis, following the same search pattern identified above, but using the key words associated with each theme.

## 2.2 Reviewing the Literature

A number of approaches for appraising the research articles were considered. Critical reading of research allows the reader to examine a study in detail and make a judgement on whether or not the study is of value to the reader (Sajiwandani, 1996). In order to be consistent in the way that judgements are made, the reader can adopt a method devised for that purpose. A number of critiquing methods were developed for use with nursing research (for example Polit *et al*, 2001; Duffy, 1985; Burns and Grove, 1983), all of which had different strengths and weaknesses. The approach chosen however, was one developed by the NPNR National Journal Club (Cutcliffe,

2003), which was felt to be the most straightforward and comprehensive to review qualitative research in a pragmatic, yet detailed and methodical way. This was preferable to using a list of questions to be answered (for example, Polit *et al* 2001). Once familiar with the article, the reader is able to assess the strengths and weaknesses of each section, which are considered individually and as part of the whole. Methodological questions are considered and reflection used to see how the study relates to existing knowledge, identifying the benefit of this knowledge to the reader. Key points can be identified to assess the strengths and weaknesses of the paper, and to obtain a balanced view of the research (see appendix 3 for a more detailed description).

The literature review began by looking at research articles that discussed transfer of care, as this was the initial aim of the study. These articles were considered in relation to the design of the study, and influenced the reviews of other literature undertaken prior to the research being conducted. This formed the key element of the preliminary literature review, and the aims of the study were refined as a result of this. Four studies were identified in total, and their relevance to the planned research considered.

### 2.3 Transfer of Care

Two UK studies were found in peer-reviewed journals, which looked at the effects of transfer during labour. The units involved were different from the study birth centre with regard to typical users of the services, and the type of service provision, and only one unit had a freestanding Midwife Led Unit (MLU).

Walker *et al*, (1995) carried out a study of 32 women and six of their partners to find out about their experiences of any aspects of midwifery-led care that they had received during the antenatal period, or during labour. Of the 32 women, six were transferred to an obstetric unit in late pregnancy, and two during labour. The study was carried out in a MLU based in a District General Hospital in Dorset, nine miles from the obstetric unit. The MLU had recently opened as a result of the *Changing Childbirth* report, (DoH 1993). The study explored the importance of continuity of carer for women and access to information that facilitated informed choice and enhanced women's feelings of control. The three issues, choice, continuity and

control were cited in the *Changing Childbirth* (DoH, 1993) report as the being the focus for planning future maternity services.

The aim of the study was stated by Walker *et al,* (1995:120) as being:

> *"To elucidate the experience of labour for those receiving any aspect of care within a midwife led unit".*

A qualitative, grounded theory approach was chosen with in-depth focussed interviews used to gather data, which were then categorised to identify common themes. The main themes identified were personal control; support from the midwife; having options and choices; being given information; and being involved in decision making. Although the study included information from women who birthed in the midwifery-led unit as well as those who were transferred, a number of issues were specific to those who were transferred. These included feelings of loss of control, and not accepting the need to transfer[2], for example, one respondent commented: *"The control was taken away from me."* (p 125). This was seen to contribute towards negative feelings about the obstetric unit, and although one woman reflected that she had accepted the transfer, none of the women felt positively about it. The research was important as it raised questions about the organisation of maternity care, ensuring that women were given adequate information to make informed choices in their care, as well as good support in labour, particularly if they were transferred. The limitations of the study were stated by the authors to be that the sample comprised women from an affluent background, and that women from ethnic minorities or areas of urban deprivation did not participate in the study. Whether this was because they chose not to participate, did not use the services on offer, or were not invited into the study was not made clear.

Even with the above limitations, this study was relevant to my own area of interest, as it used a purposeful sample of women who had received midwifery-led care, some of whom were transferred in labour and who had expressed dissatisfaction about their transfer. However, 11 out of the 32 women had only received antenatal care in the midwife-led unit, never intending to give birth there, or were transferred earlier in the antenatal period than the women I was interested in studying.

[2] Although the women did not accept the need for transfer, they did not refuse to be transferred.

The second study, carried out by Creasy (1997) also used a grounded theory approach, and looked at the subjective experiences of twelve women transferred from a community based midwifery-led service in late pregnancy or labour. The aim of the study was to explore the effects of the transfer from the woman's point of view, and the recommendations from the study were concerned with improving this experience for women. Semi-structured, taped interviews were carried out in the postnatal period, with emergent themes used to explore subsequent interviews, in keeping with a grounded theory analysis. It was stated that participants were also sent questionnaires in the ante and postnatal periods, although this is not discussed more fully.

In this study, the community-based service used a designated room within a DGH, in two hospitals in the Sheffield area, therefore there was no physical transfer to another hospital, but women were moved out of the designated room into a vacant room in the labour ward, with care taken over by a different group of carers. The purposeful sample was chosen specifically to represent a wide range of women's views, with interviews held with two women transferred in labour and ten transferred in the late antenatal period. The main finding of this study was that women were often vulnerable to feelings of disappointment following transfer that could be alleviated by adequate explanations, debriefing of events and continuity of care from a familiar midwife. Creasy (1997) linked these aspects with women's perceptions of control, which was relinquished in part when transfer occurred. Again, this study had relevance to my area of interest, although there were several limitations: the author felt that data collection and analysis were hampered as they formed part of another study, which caused problems in the grounded theory approach. Looking at wider parameters for the setting of the study would also have helped, for example, by participant observation, and using separate units, requiring the woman to move from one hospital to another.

From my perspective, the findings of the study were limited due to the small number of women who were transferred in labour (two out of twelve), and although Creasy's study aimed to get views from a wide group of women, there were few participants from lower socio-economic groups, the majority being from a professional

background. There were also differences to my proposed study: the unit was not separate from the DGH; therefore women did not have to face an ambulance journey during their labour, which might be both uncomfortable and frightening. As these were the only UK studies found which related to transfer of care in labour, the search was widened, and two further European studies were found.

A study, carried out in the Netherlands by Wiegers *et al*, (1998), looked at how the experience of childbirth was affected by being transferred from home to hospital during labour. In the Netherlands, maternity care is organised so that low-risk women can choose whether to give birth at home or in hospital, and if they want care provided by a midwife or their general practitioner. Approximately 20% of women under midwifery care need referral to an obstetrician after the onset of labour. If the woman is at home, this means being transferred to a hospital. Although the Netherlands had traditionally held a very high rate for women giving birth at home, which was stated as being 31% in 1991, the authors found there was a rising trend of referral to obstetric care, which had doubled over a ten year period. Little research had been carried out on the effects on women of an unplanned referral from home during labour. The study used two groups of women having midwifery-led care: those booked[3] for a home birth, and those booked for a hospital birth. For women planning to give birth in hospital, referral did not mean that they were moved from one area to another during labour, as in the study by Creasy, (1997), but encompassed changes in the lead caregiver and in the level of care (becoming more technology focussed).

Postal questionnaires were used, with almost 90% of women responding (1640 women in total). Women's experiences, satisfaction with birth and with the care they received were sought, together with their feelings regarding the appropriateness of the place of the birth. The study found that multiparous women did not find transfer from home a cause for concern, and satisfaction with care was not affected; they would probably choose a home birth in a future pregnancy. Nulliparous women on the other hand, felt worse about their birth experience if they were transferred from

[3] A 'booking' refers to an initial visit to the health professional with whom she intends to have care. Although it is a somewhat archaic term, it is still in common usage.

home. The main reason for this was a retrospective lack of confidence in their choice of a home birth, which would affect their choices in future pregnancies, perhaps leading to the erosion of home births in the Netherlands.

The study had an excellent response rate for a postal questionnaire, though this method of data collection is limited in the amount of qualitative information that can be obtained. Although the authors claimed that unplanned transfer had little effect on the experience of childbirth, the consequences for first-time mothers seemed to contradict this conclusion.

In this study, parallels could be drawn between the transfer from home to hospital, and from the birth centre to the DGH. This study raised questions that had not been anticipated, about how transfer affected the future childbirth plans of women from the birth centre, necessitating the inclusion of this aspect in the planned semi-structured interviews.

The final study by Wilklund *et al*, (2002) carried out in Stockholm, Sweden, looked at women's perceptions of being referred from the unit they had chosen for birth, after the onset of labour, and assessed medical outcomes such as operative and instrumental deliveries, episiotomy and epidural rates. This was different to the previous studies as referral was not due to labour complications, but due to a shortage of beds in one particular unit. The women all had low risk pregnancies, and were cared for by nurse-midwives. A study group numbering 133 women who were unable to birth in their chosen unit were compared to a group of 133 matched controls, who did birth in the unit of their choice. Postal questionnaires were sent to both groups of women after the birth, requesting both quantitative and qualitative data. All questionnaires were completed. Content analysis was used to analyse the qualitative data, a method suited to the systematic analysis of large amounts of written data (Stemler, 2001).

It was found that women who had been transferred to another unit felt that this affected their emotional state, and were more likely to have epidural analgesia, episiotomy, and require pharmacological pain relief than their counterparts, for example, 42% of women in the referred group had epidural analgesia, compared to

26% in the non-referred group. Both groups of women had felt worried about the potential for not being able to go to their chosen unit during pregnancy, and women in the transfer group had stated that they felt that this had had an effect on the course of their labour, and that they were disappointed.

The situation described in this study was very different from my area of interest, as the transfer was not because of a need for obstetric care; however, the uncertainty and disappointment faced by the women in the study highlighted how women's expectations of care might affect their experiences if they were not met. This gave me the idea of broadening my study to include an exploration of the effects of non-resolution of expectations regarding childbirth if women were transferred late in pregnancy, as well as during labour.

The four studies looked at how transfer of care in labour affected women, but each study approached the topic from a different perspective. Although relevant and informative, none of these studies provided authoritative answers to my initial research aim. This reinforced the need for further research into the aspect of transfer. Certain features were observed, such as a feeling of disappointment experienced by women who had care transferred. The importance of being given information relating to the transfer, enabling the women to continue to be involved in making informed choices about their care was also noted. The reviews above dealt with the impact of transfer of care, and have been discussed in relation to the proposed study. However, as was seen in the study by Wilklund *et al*, (2002), this was not the only factor that affected women, as unresolved expectations also played a part.

The preliminary literature review was extended to encompass some of the key findings in the transfer studies. Looking at women's expectations for childbirth, and how they compared to their experiences was the next subject for review.

## 2.4 Expectations and Experiences of Labour

Women begin to think more actively about labour and birth as the end of pregnancy approaches. Most women experience anxieties tempered by anticipation, feeling both positive and negative at the same time. Women wonder how they will cope

with the physical challenge which labour presents, and they look forward to the birth with both pleasure and dread, balancing the thoughts of meeting the baby for the first time, with the possibility that the baby will be less than perfect. Expectations for birth result from observations of life experiences, as well as from cultural, social, psychological and environmental factors (Nichols, 1996; Carr *et al*, 2001). Therefore in carrying out a review of pertinent literature, if comparisons are drawn, care must be taken to ensure that like is compared with like. The systems of maternity care vary between (and sometimes within) countries, and many publications are of a qualitative nature, thus limited in their generalisability. In the following reviews, those from outside the UK feature midwives or their equivalent in the provision of care, as discussed previously (section 2.3).

A prospective, quantitative study involving 852 women in the southeast of England was carried out by Green *et al* (1998). The women were booked to give birth in six hospitals, and recruited into the study during the final trimester of pregnancy. The sample included women booked for obstetric, GP or midwifery care, and the recruitment was organised to include a similar number of participants from each area, for statistical purposes. Women may have been in a first or subsequent pregnancy. The women were sent questionnaires during the latter part of pregnancy, and those who responded were sent another antenatal, and a postnatal questionnaire. The completed antenatal questionnaires included demographic information; women's expectations for labour and birth; and views on pain relief and medical interventions. Postnatally, women were asked information regarding the birth in relation to these aspects. Psychological outcomes of four aspects associated with labour and birth were measured: fulfilment, satisfaction with birth, emotional well being and their perceptions of the baby, chosen from a list of 16 adjectives, giving both negative and positive possibilities (for example, alert, cuddly, responsive, determined and exhausting). Questions regarding women's views of fulfilment were included, together with some asking about women's satisfaction overall, and with specific aspects such as interventions. Emotional well-being was measured using a method based on the Edinburgh Postnatal Depression Scale (Cox *et al*, 1987). This is a tool used widely in the UK to assess women at risk of developing postnatal depression. The woman's description of her baby was designed to assess the relationship, which had developed between mother and baby by six weeks postnatally.

The study found that most women felt that birth should be a fulfilling experience for them, and that most women expected this to be so. Experiences of pain in labour were strongly linked to women's expectations of this aspect, and women who were very anxious about pain exhibited less satisfaction with their experience. Being able to control their own and others actions was also linked with higher levels of satisfaction and better psychological outcomes.

The most striking finding was that there was a strong association between low expectations and poorer psychological outcomes for women, in contrast to the image often held (Green *et al*, 1998: 19) that: *"Women with high expectations are bound to feel disappointed."* Interestingly, a woman's level of education did not have any effect on expectations, feelings or experiences, so dispelling a commonly-held stereotype of the poorly educated woman who has lower expectations, and wants to hand over control to staff.

The study concluded by discussing aspects that were associated with loss of control for women, and although practices such as routine pubic shaving and the giving of enemas have been discontinued, others such as continuity of care and staff attitudes remain as a challenge today.

Green *et al*, (2003), carried out a further study, using the same parameters, to establish if women's expectations and experiences had changed in the intervening years since the first report's publication, and in particular to explore the aspects of decision-making, continuity of care, choice and control, espoused in the *Changing Childbirth* report. Questionnaires were sent out to women from four hospitals in the North and four from the South of England. These were based on the original study questionnaires.

Data were analysed from a total of 1432 women. There were some differences noted in the profiles of the women participants, for example, women were older having their first or subsequent babies, school leaving age was older than previously, more women had higher levels of education, and more women were in employment.

The main difference noted in the findings was in women's attitudes to pain and pain relief, with more women reporting that they were worried about labour pain, and wanting to have the most pain free labour possible. This was confirmed by an increase in the use of epidural analgesia. There was a decrease in spontaneous vaginal births, with a corresponding rise in caesarean section and instrumental deliveries, which was attributed to women's willingness to accept obstetric interventions more readily.

Women's expectations were broadly the same as in the previous study, but women expected to have more involvement in decision-making and felt more in control than in the previous sample, in keeping with *Changing Childbirth* recommendations. Continuity of care was found to be less, however, although the study did not explore the reasons for this. Women felt they had better relationships with midwives, and were treated with more consideration. The factor of choice was closely allied to being involved in decision-making and in having more control.

Confirming the findings in the previous study, low expectations were associated with poorer psychological outcomes, and the study concluded that by increasing a woman's self-confidence, and her expectations about labour and birth, the midwife would be aiding the woman to have a better birth experience.

Gibbins and Thomson (2001) carried out a study in the north of England, with eight first-time pregnant mothers, to explore their expectations and subsequent experiences of labour and birth. The women were chosen as a purposeful sample; the first eight women who fulfilled the inclusion criteria and agreed to take part in the study being recruited. The women were from a variety of socio-economic backgrounds. The study did not use a specific phenomenological approach, but analysed data following a process of bracketing, intuiting and reflection. Interviews with the women were carried out in late pregnancy and two weeks following birth. The women all had uncomplicated pregnancies, therefore were not anticipating medical intervention, which, it was felt, might have influenced their expectations. The interviews were unstructured; nevertheless, broad areas of interest were identified and followed, and were perhaps more accurately described as focussed interviews. The areas for study were women's expectations and experiences of childbirth, their feelings about

labour, and whether their preparations for childbirth had helped them to cope with labour. The data, obtained from transcribed interviews, were analysed using the method described by Colaizzi (1978). Of the eight women, four had normal births, whilst the remainder developed complications. These resulted in three women who had ventouse deliveries, and one woman had an emergency caesarean section.

There were two findings from women's labour expectations: hopes for a short labour (less than 24 hours), and hoping to manage the pain, with pain relief if necessary. When discussing feelings about labour, coping with pain also featured strongly. The women were aware of analgesia, which was available to them, and were open minded and realistic about using it if needed. Support from their partner was also a feature of coping with labour. Establishing women's feelings and wishes in order to provide them with a realistic view of labour and birth were cited as the main implications for midwifery practice.

The study compared the findings to the women's experiences of labour. All the women felt that they had coped well with labour. They had used various methods of pain relief, and had found them to be helpful. As well as their partner, the midwife was also found to be a positive influence, giving the women confidence and helping them to cope. Labour was found to be different from what was expected, and one woman felt that her expectations were not met, as labour had been more difficult to cope with than she had anticipated. Afterwards, several of the women talked over their labours with a midwife, which was found to be helpful in clarifying any queries they had, and filling in any gaps in their knowledge.

The effects of childbirth preparation on women's expectations and experiences are well documented in the literature, discussing how antenatal education can effectively increase a women's confidence to be in control and cope with labour, providing that they are given realistic information about what to expect, in a way which focuses on their individual needs, (for example, Spiby *et al*, 2003; Nolan, 1997). This supports what was found by Gibbins and Thomson (2001). The women all felt that their preparations had helped with labour: they had good knowledge of pain relief, so were able to make informed choices, and they were prepared psychologically, which helped them to cope. Importantly, preparations had included antenatal classes, but

also incorporated talking to other mothers, reading books and watching videos. These measures were felt to give the women feelings of confidence, allowing her to choose her method of pain relief where needed, which in turn, promoted feelings of control during labour.

In my study area, antenatal classes were provided, but were generally poorly attended. Instead, midwives held individual discussions with women to talk about labour and birth. It would be interesting to note if similar preparations for labour to those outlined above were made by women, and how effective these were.

A study carried out in Iceland also found women emphasising aspects of control and management of pain as important factors in their birth experience. Halldorsdottir and Karlsdottir (1996) carried out a phenomenological study of 14 mothers to explore the lived experience of childbearing. The mothers comprised a purposeful sample of primiparous and multiparous women with uncomplicated pregnancy, who had had normal births in hospitals in Iceland, though the study does not specify at what point the interviews were carried out (a serious limitation). The authors did not discuss the timing of interviews, so it was not possible to ascertain whether or not the authors felt that recollections were affected by the passage of time. This study used the metaphor of labour and birth being a journey that women undertook. Four categories emerged which described women's experiences: being influenced by circumstances and expectations; feeling cocooned in their own world yet needing to feel safe, supported and in control; journeying through labour and birth; and experiencing the joy and relief of motherhood.

The authors discussed how women were influenced by their culture and social background, which affected their expectations of labour and birth, for example, a single mother in the study relied on support from the midwife, rather than family or partner. Factors identified included age, life experiences, support and marital status. Other influences were whether or not the woman had previous childbirth experience. Women had mixed feelings about labour and birth; both excitement and apprehension were found. Women's expectations influenced how they felt about their experience, and there was a noticeable difference between women experiencing a first birth and those having subsequent births. Primiparous women felt more

insecure, and found the experience to be more intense than they had thought. Pain was also an influencing factor, and women found this to be different than expected, some women finding it worse, and some finding it better. All of the women talked about feelings of vulnerability during labour, and the need for a feeling of security with sensitive and caring support from the midwife. Most women also wanted their partner to share the experience with them. These two factors were found to have a positive effect on the women's experiences. Giving birth was found to be accompanied by a sense of relief and joy when the women realised that the baby was healthy. An important factor noted in the study was the need for the women to discuss their experiences with the midwife afterwards, and receive positive feedback about how well she handled labour and birth. The paper concluded by stating that if women's needs were met during her journey through labour, she was more likely to regard the experience as positive, and a key figure in assisting this process was a caring and supportive midwife.

Morrison *et al* (1998) interviewed ten couples who experienced home birth in Western Australia, four of whom were first time mothers. The women, a purposeful volunteer sample, were recruited by advertising in a consumer organisation's newsletter, and by recommendations from private midwives whose clients had expressed an interest in taking part in the study, that involved ten women who had a home birth in the Perth area within the previous two years. The study used a phenomenological approach, identifying significant themes from the interview transcripts and field notes, which were analysed using the method developed by Collaizzi (1978). Semi structured interviews were used. Three home birth videos were also analysed, one from a participating couple, and two others showing other parents' home birth videos, provided by the consumer organisation. Field notes were drawn from these, which the researchers state were used for triangulation of data, although they do not explain how this was achieved, particularly as two of the couples in videos were not interviewed during the research. The researchers did, however, contact several of the couples who were interviewed to validate the emergent themes.

The study found four themes: constructing the environment for birth, assuming control, birthing and resolving expectations. (The birth environment is discussed in

section 2.6). The theme 'assuming control' reinforced what was found by Halldorsdottir and Karlsdottir (1996), where women retreated into themselves during labour, though the women in this study relied on their family and friends for support, as well as the midwife.

The theme of 'birthing' suggested that the women in this study found the home environment more conducive to them being able to adopt comfortable positions, and mobilise more easily in labour. The time spent alone with their baby shortly after birth was significant in the women's experiences and the importance of a trusting and caring relationship with a midwife was again found to be important to the women.

'Resolving expectations', the final theme, demonstrated how the women in this study had a belief in themselves, and their ability to attain a drug-free natural birth. Five women had had home births previously, so were confident in their ability to cope with labour, and deal with the pain. The study found that most women encountered negative reactions from others when they explained about having a home birth, as this was not perceived as the societal norm in this culture. However, the opinions of others did not act as a deterrent, as seven of the women were originally from the UK, where home birth was felt to be more acceptable, particularly to family and friends, and half of the women in the study had given birth to a previous baby at home. In the study, women chose the people they wanted to be present at the birth based on their potential for giving support. This gave the birth experience a social element with grandparents and siblings often present. The experience of home birth for all of the women in the study exceeded their expectations, feeling that they had achieved something special. The central tenet was the belief in birth as a natural process, which was shared by partner and family, and supported by their midwife.

Hodnett (2002a) looked at how satisfaction with childbirth in relation to pain relief was measured, in a systematic review of 35 studies, ranging from qualitative studies with small sample sizes, to larger, population based surveys. Inclusion criteria were either a Cochrane review or equivalent standard, or a controlled trial (including RCTs) testing two or more methods of pain relief. Studies which measured satisfaction and relationships between pain and other aspects were included if there

was enough methodological information to determine the quality of the study design. The findings demonstrated that four factors were very important to women's satisfaction with their care: personal expectations; support from caregivers; relationships with caregivers; and involvement in decision-making. These took precedence over other important factors that influenced women's expectations, such as socio-economic factors, the physical birth environment medical interventions and the experience of pain. Importantly, Hodnett (2002a) draws the distinction between expectations, based on what women know of the care environment where they intend to give birth, and preferences, based on the personal wishes of the individual, reflecting that this may be a substantial difference. The review found consistency with the studies of Green *et al,* (1998 and 2003), where high expectations were associated with higher levels of satisfaction, whereas low expectations were associated with lower levels of satisfaction.

Hodnett (2002b) also looked at the relationship between satisfaction and birth outcomes, finding that although almost all women put a healthy baby as their most desired outcome, this does not automatically confer satisfaction with the birth experience. Conversely, women can be satisfied with their experiences, even when they have sustained complications, or their baby is not healthy.

Summarising this section, the review of studies of women's expectations and experiences revealed important insights into what women thought about labour and birth. Many of the studies were qualitative, with phenomenology and grounded theory being two of the methods of enquiry. This suggested possible approaches to be considered for use in the proposed study.

In the review of the studies, there were many common findings: all women had expectations for labour, although these varied between cultures, and whether the woman had experienced birth before. Pain was a feature of most of the women's expectations, and 'coping' played an important part in most women's views of their labour experiences. Coping with pain was not related to women wanting analgesia however, but to women feeling that they had made a choice about pain relief that was right for them. This was closely linked to feelings of control for women, when a loss of perceived control led to more negative feelings about the birth experience. An

important aspect contributing towards feelings of control was the type of preparation, which women had made for labour. Women obtained information from a variety of sources, including from midwives, other women and sources such as videos and books. A notable factor was that midwives needed to give women accurate and realistic information about what they might expect from labour, and how they could use strategies, or choose different methods of pain relief that would help them to cope.

In many of the studies, the relationship with the midwife played an important part, with support, feedback and trust leading to a positive experience. Positive reinforcement from the midwife contributed towards feelings of coping and fulfilment. Negative experiences resulted where women did not feel in control, felt that they had not coped well, or had low expectations of the birth experience. Low expectations were linked to poorer psychological outcomes in the postnatal period, so encouraging expectations could be seen as a positive aim for midwives. One way of achieving this was by enabling good preparation for birth. As well as helping women to cope during labour, this helped to allay anxiety and inform women of their choices, so enhancing their feelings of control.

This section of the review gave some ideas of what should be considered for the forthcoming study. Areas for consideration included women's expectations of pain and pain relief, relationships with midwives and other staff and whether women felt they were adequately prepared for birth. It was decided to review the literature on knowledge and control, which had featured prominently in the studies reviewed thus far.

## 2.5 Knowledge, Information and Informed Choice

The relationship between information and women's feelings of control has already been introduced in the literature review, with Creasy, (1997) finding that being given adequate information helped women to feel more in control when they underwent transfer of care, and Walker *et al*, (1995), suggesting that women need adequate information to be provided to allow them to make informed choices. Women's expectations and experiences of labour show how the perception of control is linked with having adequate information to make choices and decisions about care (Green

*et al*, 2003; Gibbins and Thompson, 2001), receiving supportive care from their midwife, (Morrison *et al*, 1998; Halldorsdottir and Karlsdottir, 1996). The importance of having sufficient knowledge, and the ways in which women can acquire this are explored in the next section.

Belenky *et al*, (1986), carried out an educational research case study to look at how women 'knew' information. They carried out 135 in-depth interviews with women, which were coded and analysed by the case-study method. Five types of knowing emerged from the study, arising from the ways women perceive themselves and the world, and their ideas on education and learning. The five types show distinct differences in how women process information, and according to Belenky *et al* (1986), follow an evolutionary sequence, moving from one area to the next.

The first group are the 'silent women', who possess little self and intellectual awareness. For these women, authority is followed blindly, and women choose this path as it avoids conflict, sticking to stereotypical behaviour. Women then become 'received knowers'; those who have not developed a capacity to think and reason for themselves. For these women, figures of authority speak the truth. There is no notion of right or wrong answers, and no shades of meaning. The next group of women are what Belenky *et al* (1986) call 'subjective knowers'. These women feel that they know the answer intuitively, and are pleased when their views are confirmed by authoritarian figures. The intuitive knowledge is not developed through a process of conscious thought, but is personal and valid only to themselves. It is here that there can be a clash between those in authority, if views do not coincide, as women tend to remain true to themselves. Women then become 'procedural knowers', who process information in two ways, either by listening to and empathising with others to find the truth, or by undertaking rational and objective analysis. For these women, a sense of authority is obtained through group power and knowledge. The final category is one of constructed knowledge. Here, women have the ability to think outside their own social framework, integrating intuitive and learned knowledge. This stance creates the potential for internal conflict, though this can be dealt with in a rational way. These women are able to develop their own voice, but understand that this does not automatically mean that

their opinions can be transferred to others. The five types of knowledge and the main features of each group of women are summarised in table 1.

**Table 1. Summary of Belenky *et al*'s (1986) Five Types of Knowledge**

| Stage | Type of Knowledge | Main Features of Group |
|---|---|---|
| 1 | Silent | Little intellectual awareness, follow authority blindly, to avoid conflict. Behave in a stereotypical manner. |
| 2 | Received | Undeveloped capacity to think for themselves, 'authority' always speaks the truth, without question. |
| 3 | Subjective | Has Intuitive knowledge, held to be true. Not swayed by argument or other types of knowledge; potential for conflict where views differ. |
| 4 | Procedural | Gains knowledge by rational analysis or through experiences of others, has a sense of authority through group power / knowledge. |
| 5 | Constructed | Integration of intuition and learning, can apply rationality to resolve personal dilemmas. Opinionated, but not dogmatic. |

In that study, it was found that women think in a different way to men, and are not influenced in the same way by authority, power and knowledge. Harding (1991) supports this stance, claiming that a bias created by gender differences supports feminist arguments for questioning assumptions. Irwin (2005) however, raises questions about the claims of the evolutionary nature of women's knowledge which Belenky *et al* (1986) describe, asserting that it was not possible to observe this process, as this would have required more than the one interview carried out with each woman. Whatever conclusions are reached about the work of Belenky *et al*, (1986), it is possible to recognise some of these traits in women. The concept of choice and decision-making is sometimes difficult for women when information is presented in an unbiased way, the woman being expected to weigh the pros and cons of a particular course of action, before deciding what is right for herself. Perhaps these are the women who accept received knowledge, and surrender themselves to authority, under the guise of 'they know best'. The concept of establishing how women 'know' was of interest to the study as it raised questions about the influencing factors that affected and informed women's choices and decisions about their care.

From looking at theories of how women obtain knowledge, the relationship between knowledge and making informed choices and decisions about pregnancy was then explored. Women listening to and talking to other women is discussed in section 7.7.2. Gaining knowledge from television and the internet is also popular, although how women decide whether a site is trustworthy, or contains accurate information is not known.

Lagan *et al* (2006) carried out a structured review of evidence to establish how women used the internet in pregnancy and the effects this had on their decision-making. The authors carried out searches of electronic databases such as *CINAHL, MEDLINE* and *PsychINFO* to identify published works on the subject, and contacted midwifery e-discussion groups in the UK and Republic of Ireland to identify unpublished sources. The search was limited to articles published in English, and those that related to pregnant women's use of the internet. In total, the search identified 18 relevant papers, which met the criteria, originating from the USA, Canada, the UK, Finland and Australia. The papers were then subject to a critical analysis by three independent reviewers.

The findings suggested that the information contained in the literature was diverse, mostly from small studies, and often mentioned as part of wider studies, therefore non-specific. This made drawing comparisons difficult. However, it was noted that about a quarter of women used the internet as their first choice for information, though the figure varied depending on the nature of the information sought. For example, in a study of 737 women carried out by Jacques *et al* (2004) in Australia, few women relied on the internet for prenatal screening information (between seven and nine percent), most women receiving face-to-face counselling from their health advisor.

Some benefits to women were identified from using the internet, for example, as a support mechanism for making contact with other pregnant women, or for those whose baby had an abnormality. This was weighed against the risks of using the internet, which identified the problems women face in interpreting and putting into context the information obtained. The lack of regulation on the information was also felt to be a risk, as guidance for using herbal remedies, for example, did not always

include contraindications for use during pregnancy. The main findings of the study were stated to be a lack of knowledge about what the women do with the information they obtain, and that much of the literature was based on opinion or speculation, rather than obtained in A rated studies using randomised controlled trials. The literature reviewed in this publication was diverse and non-specific, leading to difficulties in forming a strong conclusion about how internet information affected the decisions that women made.

A later study was carried out by Larsson, (2007), who looked at internet use by pregnant women in Sweden. Women attending antenatal clinics during a two-week period completed a questionnaire to establish if they accessed the internet for information, what they thought of the information they obtained, and if they discussed the information with their midwife. There were 182 completed questionnaires received, giving a response rate of 85%. The questionnaire used 13 multiple-choice questions, requesting demographic information, information about computer availability and access, the number of times pregnancy-related information had been sought and at what period of gestation. Women were also asked how reliable they felt the information was, and how they made this judgement. They were asked if they discussed information found with their midwife, and if they searched for additional information regarding a topic discussed by their midwife. There was one open-ended question asking the women to elaborate on their internet searching, and this was analysed using content analysis.

The study found that most women (84%) had a home computer, and used it to access pregnancy related information. The number of internet searches carried out by the women varied, with one woman accessing information a total of 62 times in the previous month. Most information was gathered in early pregnancy, and looked at fetal development, although women searched for information throughout. Eight percent of women accessed information regarding birth stories, and almost 40% of the information gathered was about labour and birth. The women often looked for information following discussion with their midwife, but did not talk to their midwife about information they had gathered.

Over 60% of the women in the sample were studying at university, or had a university degree, yet there was no difference between these and the less well educated women in the belief of information reliability[4]. Sixty five percent of women rated the information as highly reliable, but qualified this as being comparable to what they already knew, had heard from another source, or if it was referenced. The perception of high reliability was surprising to the authors, who had expected better-educated women to be more discerning. A number of studies were cited which were critical of the trustworthiness of internet information, for example Weiss and Moore, (2003), who carried out a survey of online information about intrauterine devices (IUD), used for contraception. There was found to be misleading and inaccurate information posted on a number of websites aimed at both health professionals and consumers.

The study concluded that it was important for health professionals to discuss internet information with mothers, to ensure that they have accurate information, and it is suggested that midwives should tell women which sites contain reliable information, advice also suggested by Weiss and Moore (2003).

Midwives and other health professionals were found to be an important source for providing information regarding pregnancy in both of the previous reviews; however, there is an underlying assumption that this information is accurate, unbiased, and tells women what they want to know, so enabling them to make informed decisions about their care. This has not always been shown to be the case. The importance of effective communication was emphasised in the NHS Plan (DoH, 2000) in relation to the well being of patients. Communication skills, however, have not been found to be of a consistently high standard amongst health care professionals, (van Nuland *et al,* 2005; McCourt *et al,* 2006). Rowe *et al* (2002) carried out a review of communication in maternity care, evaluating the effectiveness of how changes in methods of communication improved the health outcomes for women receiving antenatal care. Outcome measures included satisfaction, knowledge, and understanding of advice and treatment. The review included RCTs and quasi RCTs

[4] The educational level of the women was almost double the Swedish average, which the authors felt may have been due to a University in the county where the antenatal clinics were held.

published on health databases from 1982 to 1999. A total of 95 papers produced 11 trials, which were suitable to be included. Of these, five trials looked at antenatal screening information (Graham *et al*, 2000; Simpson *et al*, 1998; Michie *et al*, 1997; Smith *et al*, 1995; Thornton *et al*, 1995), three compared women-held records with the old system of 'co-op cards' (Elbourne *et al*, 1987; Homer *et al*, 1999; Lovell *et al*, 1987), two explored the use of computer based history taking, compared to a manual checklist (Brownbridge *et al*, 1988; Lilford *et al*, 1992), and the final trial reviewed the use of evidence based information leaflets (O'Cathain *et al*, 2001)

In trials looking at information provision for antenatal screening, positive effects were found from offering women extra information on antenatal screening, with a 'touch-screen' system being used in one area (commonly seen nowadays, but novel at the time). There was less reported anxiety amongst women who received extra information, and more women were satisfied with the information they received. The 'touch-screen' proved to be popular and effective. Extra information did not influence women to have more screening, except for Down syndrome, where there was a slight increase, and a decrease in the number of women having their baby tested for cystic fibrosis. Extra information on Human Immunodeficiency Virus (HIV) testing and the direct offer of a test, however, was shown to lead to an increased uptake, and an increase in the knowledge of HIV vertical transmission.

The maternity records trials produced contradictory results: one trial reported that the records made it easier to talk to carers, the second refuted this, but found that women were given better explanations of care. The third group of women felt that they were well informed during labour and birth. Using a computer generated record left women feeling that the midwife took longer to complete the history taking, and asked more questions, leaving less time for interactive discussion with the woman. The carrying of records, however, left women feeling that they had more control.

The informed choice leaflets trial, (O'Cathain *et al*, 2001), aimed to provide women with evidence based information which would assist them in making informed choices for care in specific subject areas. Although the women in the trial felt that the leaflets were useful, there was no reported effect on informed choice or decision-making, and no effect on women's levels of satisfaction and knowledge. The main

reason for this was felt to be due to midwives just giving the leaflet to women, but not discussing the content directly with them, as had been intended. Aspects of this study are discussed in more detail below.

Stapleton *et al* (2002) published a series of articles exploring different aspects of the informed choice leaflet trial. The focus of the research was to establish what part the midwife played in sharing information and facilitating informed choice for women. The study was an RCT in 13 maternity units in Wales, testing the effects of the leaflets, as discussed above. Several barriers were identified, which contributed to the lack of success of the leaflets in facilitating women's informed choice. A lack of time was often stated by midwives as being the reason that the leaflets were not discussed in detail, but it was felt by the researchers that there was a lack of commitment on the part of the midwives to use the leaflets as they had been prescribed – in response to specific concerns raised by women. It was acknowledged by midwives and women that although the leaflets offered women information that would facilitate choices of evidence-based care, those options were sometimes not available in that unit at that time. The authors were critical of midwives, and the systems in which they worked. There was reluctance on the part of both midwives and doctors to change traditional practices; therefore women were actively discouraged from making choices that went against these traditions. This was achieved by midwives being selective about sharing information, or by midwives and doctors using worst-case scenarios to deter women from choosing a particular course of action, for example, emphasising the dangers of home birth, rather than giving a balanced view.

This section of the literature review had revealed that women learn from a variety of sources, including from friends, family and professionals, and by using the internet. Unfortunately, no one particular method is guaranteed to provide accurate information, or give women the right type of understanding to make an informed choice. Women also acquire knowledge in different ways, which may influence their decisions for care. Having enough information was strongly linked to women's feelings of control during labour, particularly if they developed problems requiring transfer to an obstetrician. As informed choice is an inherent feature of maternity care today (for example, DoH, 1993; NICE, 2008) and particularly when the issue of

transfer arises (NICE, 2007), it seemed imperative to explore this concept as part of the study.

## 2.6 The Birth Environment

The use of the term 'birth environment' has become increasingly popular over the past few years to describe aspects of the physical environment where birth takes place and the underlying philosophy of care. The two aspects are often closely linked, and manifest as the 'atmosphere' that is perceived by women and their families, midwives and other carers, and which can be felt to have a positive or negative influence on labour and birth.

Both aspects of the birth environment are important to women; the physical environment because naturally, women want to feel as comfortable as possible during labour and birth and the type of care which focuses on the woman because this can affect her experiences of birth. Comfort arises from a relaxed, calm environment as well as easy chairs and birthing aids, which might be present. Being the focus of care means that women are in control of their environs, playing an active role in decision-making. A calm environment can be promoted by allowing a supportive and trusting relationship to build between the woman and her carer, benefiting both mothers and midwives (Huber and Sandall, 2008). The antithesis of this is described by Hanson *et al* (2001) as being analogous to a '*theater* [sic] *of birth*' (p.18), where the woman is cast in the role of 'patient': passive, submissive and disempowered. This somewhat novel view nevertheless describes the effects of a clinical environment on women, a premise supported by others (Campbell and Macfarlane, 1990; Steele, 1995; Lock and Gibb, 2003). It is not difficult to imagine how mothers can feel intimidated by an unfamiliar environment that is clinical in appearance.

Literature about the birth environment falls broadly into three categories: women's views, how the environment affects the outcome of labour and how it impacts on well-being and satisfaction. The following discussion explores how these themes relate to the birth environment.

### 2.6.1 Women's Views on the Birth Environment

Childbirth signifies one of life's major events, and where and how this takes place influences the memories of women and their family and friends, and the way in which women adapt to the role of being a mother (Ball, 1988). It is therefore not surprising that women want these experiences to be positive and special. Consequently, promoting a good birth environment is important to maternity care providers. Women are not an homogenous group however, and factors that are important to some women may not have the same implications for others.

Hundley *et al* (2001) explored the use of a research tool, the Discrete Choice Experiment; to find which attributes women felt were most important to be available in maternity units. A purposive sample of 301 women in the Grampian region of Scotland were given an anonymised questionnaire, where the respondent is asked about their preferences during certain scenarios, in this case maternity care. Surprisingly, the findings were suggestive of women wanting higher rates of intervention than had been previously thought, such as intermittent cardiotocograph monitoring and routine medical involvement. Although the findings of the study were limited due to issues with validation of the research tool for use in maternity care studies, the authors suggested that women's preferences for care needed further exploration.

Hodnett (2002b) carried out a systematic review of factors influencing women's views of their experiences of childbirth. One hundred and thirty seven reports were scrutinised, including randomised controlled trials, systematic reviews of interventions during labour, and qualitative, descriptive studies. Four factors emerged as very important in the review: the relationship with caregivers, the support given by caregivers, personal expectations and being involved in decision-making. Other aspects such as management of pain relief, the physical birth environment, and continuity of care were found to be of lesser importance. These findings were interesting in relation to the aspect of continuity of care. Having a named midwife who provides a majority of care throughout was signalled as being one of the goals of *Changing Childbirth* (DoH 1993) but achieving this has been a challenge to the organisation of maternity services: schemes which provide continuity of care require

a change in the culture of the workplace, becoming women-led, rather than service-led, as in more traditional models (McCourt *et al*, 2006).

A UK study carried out on behalf of the National Childbirth Trust[5] (NCT), by Newburn and Singh, (2006), found that women believe that the birth environment can affect labour and birth. The study, a survey of a self-selected group of women in the UK, was in response to a questionnaire given out to women by a baby marketing company following birth. The 676 respondents were felt to be a fairly representative sample of women who had given birth in a variety of settings during the previous year. The women gave information on the physical environment that they wanted, or felt was important during labour. This included access to private bathroom and toilet facilities, general cleanliness, using the same room for labour, birth and postnatal care, and being able to move around freely in labour. Other aspects included the comfort of their birth partner and access to aids such as birth pools for use in labour, and a comfortable, relaxing environment. Factors that women felt were detrimental to labour included a clinical environment, and not enough space to move around. The group of women included those who gave birth at home and in birth centres, as well as in traditional hospital environments. This study reinforced a previous, larger NCT study of mothers who responded to a NCT website and magazine questionnaire, and gave broadly the same findings (Newburn and Singh, 2003), though was received more critically as the respondents were all members of the NCT, therefore not a representative group.

Given the aspects which women felt were most important, and that almost half of respondents reported lacking access to homely rooms or private bathroom facilities in the units they used, it was surprising that there were so few women (only 2% of respondents) who chose to give birth at home, where many of the above items are readily available, although cultural and sociological factors are also of importance here. This study led to the development of an audit toolkit by the NCT *'Creating a Better Birth Environment'* for use by NHS Trusts to obtain women's views about

[5] The NCT is an organisation that aims to make pregnancy, birth and parenthood fulfilling experiences for women and their families. They offer evidence-based information to help women to make informed choices, and campaign for the provision of better maternity facilities for women.

their local facilities, with many of the factors included on the '*Dr Foster*' website, which gives a comparison of facilities available in maternity units throughout the UK [http://www.drfoster.co.uk].

### 2.6.2 How the Environment Affects the Outcome of Labour and Birth

Studies of outcomes include a variety of options, for example: whether the birth was normal (depending on the definition, if any, that was used), what analgesia the woman took, if she had an episiotomy or perineal tear. These outcomes are primarily concerned with avoidance of morbidity, and the successful outcome is measured in terms of a medical event. For women, important outcomes may well have different measure, perhaps how they coped with labour, if expectations were fulfilled and so on. Lewis (1990) suggests that often there is a discrepancy in the measure of a successful outcome between health care staff and mothers as they are approaching the matter from completely different angles, one from a health policy aspect, and the other from a personal and psychosocial one. Of course, for both parties a healthy baby is also the desired outcome but it is essential to remember that for women, the manner in which labour and birth take place is also important.

Several studies have looked at influences on birth outcomes. One such study was carried out in the early 1990s by Hofmeyer *et al*, (1991), who explored factors which might have a positive influence on women's experiences and outcomes of labour, thereby enhancing the process of childbirth. Their study, a randomised controlled trial of first time mothers in South Africa compared the use of supportive disinterested companionship in labour to those where no companionship was provided for women giving birth in a clinical environment. They found that support helped the women's feelings of self esteem, and it had small but noticeably beneficial effects on the use of analgesia, diastolic blood pressure and women feeling that they had coped well with labour. There was no effect on the length of labour. Interestingly, the clinical environment was highlighted as being the factor, which had the most detrimental effect on women's confidence in adapting to motherhood.
A systematic review was carried out by Hodnett *et al*, (2005), for the *Cochrane Database of Systematic Reviews*, comparing the effects of a home-like birth environment or conventional labour ward environment on labour outcomes, and also to see how models of care, staffing and the situation of home-like settings influenced

labour and birth. Six randomised controlled trials using women considered to be at low risk of obstetric problems were reviewed (Klein *et al*, 1984; Chapman *et al*, 1986; Macvicar *et al*, 1993; Hundley *et al*, 1994; Waldenström and Nilsson, 1997 and Byrne *et al*, 2000). The trials were carried out in the UK, Stockholm, Montreal and Australia with a variety of outcome measures compared. These included aspects of obstetric care, views on care and transition to motherhood by the mothers, infant feeding and health progress. The review did not include home births, or births in a free-standing birth centre. The main findings of the review were that a large number of women developed complications that required them to be transferred from a home-like to a conventional hospital setting. The benefits from a home-like setting were less medical intervention and increased satisfaction with care and initiation of breastfeeding.

The review, using criteria of measuring perinatal outcome by original intended place of birth, found an elevated risk of perinatal mortality, a facet that led to debate about the relationship between actual and intended place of birth (Fahy and Tracy, 2006).

### 2.6.3 Well-Being, Satisfaction and the Birth Environment

The measurement of satisfaction with care is a fairly recent innovation in the NHS, arising mainly since the 1980s in the UK. In maternity services, this began with the introduction of Maternity Services Liaison Committees (MSLC) in each District Health Authority, following a directive from the Department of Health and Social Security (Inch, 1986). Part of the role of this group was to elicit patients' satisfaction with their care, an area fraught with professional opposition (Sitzia and Wood, 1997). *Changing Childbirth*, (DoH, 1993) was the catalyst for strengthening the role of the MSLC to ensure that maternity services were developed with due regard to public involvement and representation, and they reported directly to the Primary Care Trusts in England, and Local Health Boards in Wales, (DoH, 2006).

Over time, the role of the MSLC in conducting surveys of women's experience and satisfaction with their care has become a valuable asset to maternity departments. Measuring satisfaction is not a simple process, however, and the concept of what constitutes satisfaction is often poorly understood, especially as professionals often set the questions, and as discussed above, do not necessarily have the same view as the service user regarding which issues are important (Williams, 1994).

Crow *et al* (2002) in a systematic review of literature for a refereed monograph advised that there were two main groups of factors which affected satisfaction: those relating to respondents' characteristics, and those which related to the way in which the service was delivered to them. Importantly, they recommended that researchers ensure that data were collected with due regard to both points before findings were used to change practice. The use of appropriate methodologies is also recommended by Redshaw, (2008), who suggests that by listening to women and their partners, valuable lessons can be learned from measures of dissatisfaction, as well as satisfaction. Satisfaction is often explored in relation to the type of care given to women. Several studies, which reported on women's satisfaction with maternity care and services have already been discussed above (Hodnett, Downe, Edwards and Walsh, 2005).

The support and relationship with caregivers was a feature of a randomised controlled trial looking at satisfaction with midwife-managed care in Glasgow carried out by Shields *et al* (1998). In this survey, 1299 women were given a series of questionnaires looking at satisfaction with care during three separate time frames (antenatal, intrapartum and postpartum care). Care was given either in the traditional 'shared care' model, or as part of a midwifery-managed model. The study was designed to ensure that methodological difficulties with eliciting satisfaction were addressed. The organisation of care in the two models meant that women in the midwifery managed group had better continuity of carer (see section 4.3) throughout, as the service had an integrated team of midwives working through both hospital and community, whilst the shared care model group experienced a more fragmented approach to care. Similar areas of dissatisfaction were found between the two groups, mainly associated with the provision of information, which facilitated choice, but overall, women in the midwife-managed group had consistently higher levels of satisfaction throughout (over 80% through all aspects, compared to a range of 52% - 92%, for the shared care group).

A survey of maternity users carried out in England and Wales asked women to evaluate their experiences of childbirth. The study involved 2,375 respondents who had given birth within the preceding few months, asking questions on topics identified 0in research as being important to women, or that reflected current health

policies (Audit Commission, 1997). Overall, women were satisfied with the care they received and the expertise of their carers. They felt less satisfied with the relationships they established, and the attitude of carers. Minority groups of women felt less satisfied, as did those women who did not fulfil their expectations and desires for labour and birth. The need for providing good information to allow women to be fully informed about their choices, and to make decisions about their care was again noted as a cause for dissatisfaction.

In summary, the birth environment encompasses physical aspects and care provision, both areas that have importance for women, and that colour their expectations of labour and birth. Women want to have pleasant, safe surroundings in which to labour as they feel that this can affect the progress of labour and birth, but this concept does not hold the same meaning for all women. Although a clinical environment can be intimidating, some women feel more comfortable if they have access to specialist equipment such as fetal monitors and epidural analgesia; whilst for others, this is anathema. Trusting relationships with caregivers are important for women, and feeling supported and informed gives women better feelings of satisfaction. Measures of satisfaction are not easy to achieve, however, as the concept is complex, and the practice of measuring satisfaction allied to the outcome of labour and birth needs to be approached with caution: women have different outcome measures to those of caregivers, and the two are not necessarily compatible.

The relationship of the birth environment to women's perceptions of care, and therefore, perhaps to their dissatisfaction, seemed to be an important aspect. In the forthcoming study, the birth centre and DGH offered different facilities and types of care. The birth centre concentrated on normal pregnancy and birth, whilst the DGH dealt with complex pregnancy situations. This meant that the DGH provided a technology-focused service that was reflected in the environment. Whether this had any influence on women's choices was not known, but was an area identified for further exploration.

## Chapter Three: Theoretical Considerations

A theoretical approach gives the researcher a stance from which to explore, analyse, understand and explain data. Silverman (2005: 39) calls this a '*settled theoretical*

*orientation',* which he suggests should fit with the researcher's aims, and be congruent with the method of enquiry. This chapter discusses the main theoretical influence for this study, that of social constructionism. The reasons for making this choice are discussed, and an outline of social constructionism presented. The main theories and concepts are discussed.

One of the main considerations in this study was concerning the different backgrounds and viewpoints that women may have. As Downe, (2004: 174) remarks:

> *"Birth… is catalytic in women's lives and beyond that, in the lives of their families and the wider society."*

The study area included a mix of social neighbourhoods, from those where high levels of social deprivation occurred, to more observably affluent areas. I sensed, therefore, that this was likely to give women different priorities in their daily lives, as well as from the care that was on offer for pregnancy and birth, but it did not necessarily follow that women from poorer backgrounds had fewer expectations from their care. There was evidence of stereotyping women (see section 4.4), but no one had explored local women's beliefs and values, to see how these related to their experiences and choices of maternity care.

Social constructionism offered a different way of looking at influencing factors in women's lives, which was not based on my own assumptions. As Willig (2001: 7) states:

> *"Social constructionism draws attention to the fact that human experience, including perception, is mediated historically, culturally and linguistically."*

## 3.1 Social Constructionism

Further reading about social constructionism reinforced this view. When exploring how women were defined as mothers, Phoenix and Woolett (1991) considered how women were judged in their role as mothers. They concluded that the notion of being a good mother had little to do with what actually took place in the nature of care for their baby, but was more to do with idealised views of motherhood that were

generally accepted by society. As an example, they suggested that a white, middle class mother was more likely to be perceived as a good mother. Although they acknowledged that race and class (therefore socio-economic status) could present challenges for women, Phoenix and Woollett (1991) pointed out that within any race or class, people vary, and their potential for being a good mother would also vary. They maintained that the concept of motherhood was a socially constructed entity influenced by political and psychological values.

Although my study was not to be about motherhood in the above sense, social constructionism seemed to offer an opportunity to look at the influences which led women to make their choices, or shape their expectations and experiences. It was for this reason that I decided to use social constructionism as a stance from which to base my research. This is a complex theory that is also fluid in nature. I have, therefore, provided a critical appraisal of the relevant aspects of the underpinning characteristics that seem pertinent for this study.

### 3.1.1 Theories of Social Constructionism.

Giving a concise definition of Social Constructionism is problematic: it is used in a number of disciplines each with a different approach, so incorporating the possibility of many definitions. The theory also causes a philosophical problem; to give a single definition is anti-constructionist, (Burr, 2003; Gergen and Gergen, 2003). Willig, (2001), however, uses a common-sense approach, investing social constructionism with the opportunity to look at individual perceptions, influences and experiences in relation to the environment in which they occur.

There is no clear-cut historical starting point for the development of Social Constructionist theory, though it became widely known as a means of looking at what was meant by the concept of 'reality', when proposed by sociologists Berger and Luckman, in a book entitled The *Social Construction of Reality* (1966). They wanted to understand the sociology of knowledge and explore how this knowledge developed in people, coming to the conclusion that there were two different ways how this occurred. The first, which they determined through phenomenological analysis, showed how the experiences of everyday life influenced people. Their views of the world were prejudiced by the culture in which they lived, and as they

became a member of that society, they adopted its systems of values and beliefs. Berger and Luckman (1966: 33) called this *'the reality of everyday life.'* The second way was dependent on a more subjective stance. As people developed a more individualist sense of identity, they constructed their own interpretation of reality, built on their own values. Berger and Luckman, (1966: 149), called this '*internalisation of reality'* and felt that this second aspect linked closely with the field of psychology.

Social constructionism in psychological research was developed by Gergen, who proposed that existing methods of psychological research were flawed by what he called '*cultural imperialism'* (Gergen, 1999: 17). By this, he meant that the researcher's beliefs and values influenced their analysis of people, who were being judged by cultural systems that might be radically different from their own. Gergen felt that social constructionism offered the opportunity to understand people as individuals, a product of their background.

Today, it is used in the areas of psychology and social psychology, under the terms of 'critical psychology', 'discourse analysis' and 'discursive psychology', (Burr, 2003), but has been used in many different studies such as exploring behaviour, (Shrimp, 2001), and to establish health professionals' views of adolescence and motherhood (Breheny, 2006). Table 2 (p 52) outlines some of the key authors using social constructionism within their field.

Having established that there is no one definition of social constructionism, it is possible to look at the features that characterise its use across disciplines. Certain features that occur in the various disciplines form a useful way of characterising the ways in which it can be used (Burr, 2003). My discussion begins with the concepts of reality and truth, subjects that have close links with the discipline of philosophy.

**Table 2. Examples of Key Authors and Publications Associated with Social Constructionism**

| Author | Date | Publication | Field | Contribution to theory |
|---|---|---|---|---|
| Peter Berger and Thomas Luckman | 1966 | The Social Construction of Reality: a Treatise in the Sociology of Knowledge | Sociology | Claim that reality is socially constructed and discuss its relationship to the sociology of knowledge |
| Kenneth Gergen | 1973 | Social Psychology as History | Psychology | Asserts that all knowledge is linked to historical and cultural influences, and that this is a continually evolving process |

| | | | | |
|---|---|---|---|---|
| Paulo Friere | 1978 | The Pedagogy of the Oppressed | Education | Develops "nutritionist" theory, which discusses how educational methods stifle learning, and suggests that students should approach subjects from different, non-traditional viewpoints. |
| Robert Connell | 1987 | Gender and Power: Society, the Person and Sexual Politics | Social Science | Theorises about the socially constructed nature of gender, concluding that there are three aspects that influence gender relations within society: gendered division of labour, power relationships and emotionally focussed social relationships. |
| Vivian Burr | 1995 | An Introduction to Social Constructionism | Psychology | An advocate of social constructionism, discusses and critically appraises the main theoretical and practical approaches, together with associated research issues. |
| John Searle | 1995 | The Construction of Social Reality | Philosophy | Explores the philosophical notion of 'social reality' – how social institutions fit into a factual and metaphysical world, and the notions of truth and reality. |
| Ian Hacking | 1999 | Teenage Pregnancy: Social Construction? | Philosophy | Discusses the implications of labelling teenage pregnancy as social construction, which carries political connotations that may not be helpful in addressing the issue. |

### 3.1.2 The Concept of Reality

Philosophers try to answer the question 'what is reality?' (See for example Russell, 1978). In philosophy our senses cannot be relied upon to tell us what is real. Common-sense realism is the view held by non-philosophers, (Warburton, 2004). This hypothesis is based on an assumption that objects exist in the physical world, regardless of individual perception. As a very simple example: I know that the flowers in my garden exist regardless of whether or not I am seeing them. People also have a collective acceptance that individual perceptions match those experienced by other people, again, to use the analogy of flowers as an example, we know that some flowers are red. Of course, we don't know if red is perceived as exactly the same colour by you and me, but we accept that red is red. Social constructionists' views about perceptions of reality follow similar lines, as Searle, (1995: 173) suggests:

> *"When we deal with the world in perception, thought, inquiry etc., we are always working from within some conceptual scheme."*

This argument claims that we can never experience reality as we are always influenced by what others have described this reality to be. Reality exists, but independently of the individual, and of the individual's understanding of it. This is labelled as 'realism'. Realism accommodates an acceptance that individual interpretations of reality are influenced, and therefore constructed through experiences and social background. The opposite view posits that reality only exists within individual knowledge, constructed through our social experience. This is

known as anti-realism or relativism. These positions represent the two extremes of social constructionist views, with many stages in between.

In the search to establish the nature of reality, the philosophical principles of ontology and epistemology have been discussed: ontology relates to existence and being, and epistemology to the science of knowledge and how and what people know (Holloway and Wheeler, 2002). Ontologists such as Berger and Luckman, (1966), believe that a person's construction of their world is shaped by the social circumstances in which they live. The 'real' world exists independently of this view, but the perceived reality for that individual is influenced by values and beliefs that are held within the culture in which they live. Gergen, (1999), following an epistemological stance, considers that other influences contribute to our constructed lives: he singles out the power of the media in affecting the way in which people view themselves, their values and sense of identity.

Opinions against taking a single stance on the principles of ontology or epistemology include that of Edley, (2001), who thinks that arguments about whether an ontological or epistemological approach is used are self-defeating. He posits that to take one approach or the other invites criticism, which deflects from the value of the research.

As both approaches can be facilitated in social constructionism, I conclude that perhaps the middle way of adopting both stances provides better knowledge, analysis and understanding for the researcher. What I have done in my study is to look at the way historical influences have shaped women's views and opinions, but also to consider the effects of external factors such as the media, which may have contributed towards women's cultural identities.

### 3.1.3 The Concept of Truth

Closely linked to reality and realism is the notion of truth.
'Truth' may be based on an interpretation of reality which is presented as an unassailable fact, (Potter, 1996), a practice not unfamiliar in the medical world (see Donnison, 1988; Ehrenreich and English, 2008). An example that illustrates this point shows how the advice of doctors in the 18$^{th}$ century gave weight to the political

and social view that middle class women should not pursue a career or higher education, as it would affect their ability to have children. Although there was no scientific evidence to support this, because the medical establishment put the view forward, it was given more credibility and accepted as truth (Wright and Treacher, 1982).

In accepting a 'true' fact without question, Gergen (1999) feels that we are being too closed-minded, needing to be more open to other ideas and interpretations. It is not until we begin to question facts presented as truths that we realise how relative the concept of truth is, and how easily one person's truth becomes accepted as reality.

### 3.1.4 Personal Agency

Other qualities of social constructionism suggested by Burr, (2003), include the matter of what she calls personal agency. People have an individual power to carry out actions as a result of making choices. There is a consequential nature to exerting this personal power, which the individual can justify by showing the influences and biases that led them to the decision. Personal agency is influenced by two factors that Burr (2003) calls 'micro' and 'macro' social constructionism. Micro social constructionism is closely tied to the discipline of linguistics, and is often used to study interactions between people, for example, by discourse psychologists. Macro social construction, on the other hand, is concerned with the concept of power and how this gives rise to social inequality. The ways in which social institutions and organisations contribute to inequalities of power are often a feature of macro social constructionist research, and are particularly influenced by the work of Foucalt (for example, 1977). A sense of personal agency is not available in macro social constructionism, as the individual becomes the passive recipient of social power, and has no capacity to make changes or exert their personal views. Macro social constructionism has been used by feminist researchers to show the relationships between gender and power (Weir, 1994), and how medical power is exerted under the medical model of care (Ehrenreich and English, 2008).

Burr (2003) advises that micro and macro social constructionism are not mutually exclusive, and that both may be used to provide a wider viewpoint in research. Personal agency was a feature of developing the concept of woman centred care,

with the woman being empowered to make her own choices and decisions. I felt that the aspects of both micro and macro social constructionism were evident in some studies reviewed in chapter two (Walker et al, 1995 and Creasy, 1997) therefore had relevance to my study.

### 3.1.5 Cultural Norms

A major feature of social constructionism is its contemporaneous nature. Our cultural and historical background shapes the way in which we understand the world as individuals. This means that our observations and interpretations may change over time, as the norms within our society change, (Burr, 2003). For example, 50 years ago there was great social stigma attached to illegitimate birth and single motherhood, whereas today it has become an accepted norm – in Wales, over half the births take place outside marriage, (WAG, 2008).

Our knowledge of the world is determined by the perspective from which it is viewed, and it is here that Burr, (2003) along with Gergen, (1999), urge us to be critical of our own viewpoint when trying to understand that of another, moving away from our own '*taken-for-granted ways*' (Burr, 2003: 2). An ethnographic study by Hunt, (2004), using a social constructionist framework, demonstrated the challenges this represented to a researcher. Her study was about understanding the concept of motherhood in a socially deprived area of Britain; how this was viewed by women and midwives. Hunt thought that she would be able to understand these women as she came from a similar background, and went to live in the study area during the period of research. However, she acknowledged that her efforts to become integrated into that society were unsuccessful. She did not originate from the area; her children did not attend local schools, therefore had little common ground with women, and was always considered as an outsider. To overcome this and maintain the social constructionist approach, she interviewed childbearing women, their mothers and grandmothers in an effort to understand the prevailing culture. Her study found that midwives held certain views on women because of their social status, echoing the image of stereotyping found by Green *et al*, (1990), (see section 2.3), with Hunt exhorting midwives to look at the world from the woman's point of view, which is the theoretical approach being taken in this study.

### 3.1.6 Language

An abiding feature of societies and cultures is the use of language. Language, more than any other form of communication, is used to share and express knowledge and accounts of experience, and is therefore perhaps the one common theme of social constructionism (Burr, 2003). Language is used by people to convey their own meanings and interpretations of events, giving a representative account of reality, (Edley, 2001). It is important to note that these accounts are personal versions of the world, rather than the truth, (Potter, 1996). Language is also versatile and can be used in many different ways to describe the same episode, (Willig, 2001). Although there is no one research method suggested for use with social constructionism, language is a central feature of the theory, therefore fits with qualitative research methodologies such as phenomenology that use interviews as a means of gathering data.

## 3.2 Social Constructionism as a Theoretical Influence

There were a number of reasons why social constructionism provided theoretical considerations for the study. There were many possible factors that affected how women were able to make choices about maternity care, and which subsequently shaped their experiences of labour and birth. These included historical, social, cultural and medical influences. As social constructionism is not tied to any one discipline, (Potter, 1996), it was possible to explore the subject from a multidisciplinary standpoint. This was essential in trying to unravel how and why women felt as they did about their experiences. Importantly, the knowledge gained from this study could be used for a practical purpose, suggested by Gergen and Gergen, (2003), to identify areas for positive change in the way that care was provided, doing so in a way which actually met women's needs, rather than what was perceived of women's needs.

Social constructionism is an appropriate choice for a qualitative study, (Burr, 2003), and it sits well with the use of Gadamerian phenomenology and thematic analysis, the method chosen for analysing the data gathered in this study (see chapter five). This is because it acknowledges that the researcher can never be entirely neutral, that we too are shaped by our backgrounds (Ekdawi *et al*, 2000). As a midwife of long standing, and a nurse prior to this, I had been subject to many influences associated

with the medical model of care. This was the culture accepted without question for the initial part of my career. As my career progressed, I began to question the medical hegemony that existed in the maternity services; I became more radical. This was helped by the development of midwife-led services that actively sought to redress the imbalance of power between professional and woman, treating the woman as an equal in her care. Today, through reading about the medical model of care from the standpoint of feminists such as Ehrenreich, (2008) and sociologists such as Jones, (1994), I understand how my original viewpoint of health, women and maternity care was constructed, being based in the medical model. My views have changed over time, but I need to be vigilant, as the medical model forms the 'default mode', which sometimes goes unrecognised. By adopting a social constructionist stance, I have found a way of guarding against unintentional stereotyping, and to look beyond my own perceptions, to let women speak for themselves.

### 3.3 Summary

Social constructionism has no precise definition as it means different things to different people, and there are a variety of approaches that may be followed. What the theory does facilitate however, is the idea of incorporating into research how individual interpretations of the world are influenced by the social world in which people live. Although social constructionism was not the method chosen for this study, using this as a stance to approach the research meant that the cultural influences that affected participants would be actively sought, and would provide me with a different way of seeing life in Cwm Fechan. Social constructionism also provided an insight into how the background for the study should be explored. The historical influences on the valley community, and the life of women there formed an important backdrop to life in the valley today, and importantly, to the way in which maternity care was provided: the subject of the next chapter.

# Chapter Four: Background to the Study

This chapter explores the background to the study: putting the study into context. The cultural and social history that has influenced women in the area and predisposed their values and beliefs is explored in order to gain an understanding about life in Cwm Fechan today. The communities within Cwm Fechan have been shaped by their industrial past that has impacted on their views of health, and illness. Childbirth has also been subject to the influences of the past, in the way that maternity care has developed and been influenced by political and medical agendas. In the United Kingdom, the rise and influence of the medical model of care has historically dominated childbirth (Doyal, 1991; Donnison, 1988; Oakley, 1986), and is explored in section 4.2. Some feminist views of health and childbirth are discussed, together with key political issues that have affected how women give birth in the UK. Finally, the development of the birth centre in Cwm Fechan is explained.

## 4.1 Cwm Fechan, Past and Present

Cwm Fechan is situated in an area of former heavy industrialisation that left its mark on the landscape and the local communities. The valley (typical in South Wales) is recognisable for its mixed urban and rural landscapes which arose out of the industrialisation process - the flat land of the valley floor used for heavy industry – initially iron production and later coal mining, now in a process of 'regeneration'; the middle third of the valley side occupied by long rows of terraced housing, a dense urbanisation of villages merging into one long street of houses and reclaimed coal tips; above, in complete contrast, a rural, glaciated upland with farms, sheep and pine forestation.

Prior to heavy industry, the South Wales Valleys were sparsely populated agricultural areas, however, the mid 18$^{th}$ century heralded the beginning of iron working. The turn of the 19$^{th}$ century saw ironworks established in Cwm Fechan, reliant on the limestone and coal that were easily accessible. Industry brought people, and the population of the valleys increased. This process was likened to that seen in parts of America with the coming of the railroads, or with the gold-rush (Smith, 1993). Technology (especially the invention of the steam engine) meant that coal could be mined to sell in its own right, and soon the coal industry replaced iron working (Williams, 1977). The population of Glamorgan, a large shire in the South

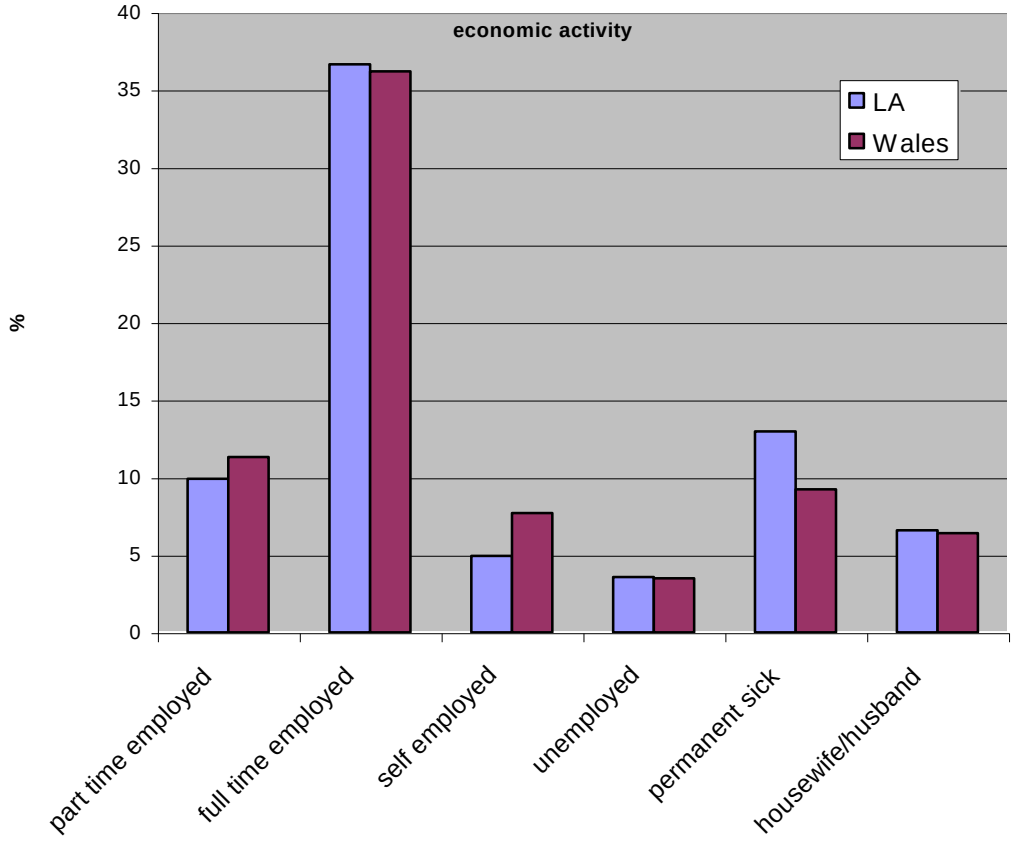
Wales coalfield, increased by 77% over a forty year period, with people mostly moving from the South West of England and Ireland (Williams, 1977). Local housing was built around the mines, eventually becoming villages, each separated from the other by its own identity, their existence being centred around a common purpose: mining coal. Frederick Engels writing of 'The Great Towns' in his study of the Condition of the Working Class in England 1892, mirrored the conditions which prevailed in Wales fifty years earlier: poor unsanitary housing, overcrowding, the spread of disease (including Cholera), exploitation by the coal owners who held a monopoly on housing and other provisions.

For an outsider, the ending of one village and the beginning of the next is not so distinct, but as Hannan (1999) suggests, local people are very quick to point out which village they belong to. The decline of local industry has bought about social change in the valley – Hannan (1999) feels that people now lack a 'sense of place', and there is a decline in the feeling of community. Even so, there are now new housing estates being built throughout the valley that are introducing new communities, and bringing affluence into the area. House prices are lower than those in or near to Cardiff or Swansea, thus affording people a better standard of living.

### 4.1.2 Demographics, Economic Activity and Health

A review of the (2001) census for England and Wales was carried out to provide the statistics, graphs and tables presented in this section (Office for National Statistics, 2006). Cwm Fechan was part of a Local Authority, the smallest area for which information gathered in the census was available. The Local Authority population was 231,946, with little change over the previous 10-year census period. Ninety percent of the population were born in Wales, in contrast to the 18$^{th}$ century. Graph 1 shows economic activity in the Cwm Fechan Local Authority compared to Wales as a whole. As can be seen, the most marked difference is in economic inactivity due to permanent sickness or disability.

**Graph 1. Economic activity, Cwm Fechan Local Authority (LA) and Wales**




(Source ONS 2006)

Graph 1 shows that there were a higher proportion of people of working age who described themselves as having a limiting long-term illness – 4% higher than the figure for Wales. Table 1 below shows the figures for people's assessment of their state of health in the preceding 12 months prior to the census.

**Table 3. Health Status: Cwm Fechan and Wales**

| | Local Authority | Wales |
|---|---|---|
| Good | 61% | 65% |
| Fairly Good | 23% | 22% |
| Not Good | 16% | 12% |

(Source: ONS, 2006)

The Welsh Assembly Government confirmed that poor health remained a problem in Cwm Fechan, associated with the observed patterns of deprivation (WAG, 2003). The Welsh Index of Multiple Deprivation (WAG, 2005) is a tool used to compare

similarly populated areas throughout Wales[6] in order to target resources into the poorest regions. The Local Authority ranked third in Wales for areas of multiple deprivation, with almost a fifth of its districts being in the top 10% of those most deprived, and one village in Cwm Fechan being classed as the third most deprived place in Wales.

Within the UK, there is a growing emphasis on getting people to take more responsibility for their own health as outlined for example in the *Wanless Report* (Wanless, 2002). However, the extent to which individuals subscribe to this view is a cause for debate: a limited readiness to accept accountability for illness was found in a sample of 41 working-class mothers living on the outskirts of Cardiff, (Pill and Stott, 1982) whilst women in low income families were more likely to choose to smoke and eat unhealthily and not breastfeed their babies in an attempt to manage their own lives (Symonds and Hunt, 1996).

### 4.1.3 Women's Health in Cwm Fechan

In recent studies, the National Public Health Service for Wales (NPHS, 2007) found that the number of women in Cwm Fechan who smoked was higher than the Welsh average, with a corresponding rise in lung cancer and other associated respiratory diseases. Smoking is known to cause problems during pregnancy, contributing significantly to babies being of low birth weight, the prevalence being higher by 1% in the Local Authority (Office for National Statistics, 2006) than in the rest of Wales. Low birth weight is associated with a higher infant mortality, and is often the beginning of long-term ill health (Stevens-Simon and Orleans, 1999).

Historically, women's health in the locality was poor, and another factor associated with low birth weight, the poor nutritional status of the mother (HDA, 2003), was first studied in the valleys area by the Birthday Trust, a UK organisation established in 1928 to try and reduce the maternal mortality rate.

[6] Wales is divided into basic units containing approximately 1500 people, known as Lower Layer Super Output Areas, or LSOAs. This allows areas to be compared, following overall measurement of deprivation which includes income, employment, health, education, housing, physical environment and access to services.

Maternal deaths in Wales average at around one per year at present; the annual number of births is approximately 32,000 (WAG, 2008). The maternal mortality rate in England and Wales during 1928 was 442:100,000 births: approximately one woman dying per 250 births (Williams, 1997). In addition to those women who died, many suffered long-term ill-health (Oakley, 1984).

The Birthday Trust recognised that maternal deaths in a South Wales Valley that mirrored Cwm Fechan were higher than the national average but little was known of why this should be. Various ways of dealing with the problem were tried, such as supporting local midwives with a combination of education, basic hygiene equipment and remuneration for complicated cases that needed referral to an obstetrician. Increased antenatal care was provided, following a model adopted in Lancashire in 1930, which had led to a dramatic decrease in maternal deaths. There was no positive effect from these interventions and the maternal mortality rate continued to rise (Williams, 1997). Eventually, it was recognised that the women were suffering from malnutrition: this was a time of economic depression, strikes and 'hunger marches'. Food subsidies were introduced which seemed to have a dramatic effect by halving the death rate by the following year (Williams, 1997).

Poverty was recognised as a cause for maternal morbidity and mortality, but it was not the only contributory factor. Women from middle class backgrounds, attended in childbirth by doctors also had high mortality rates attributed to poor obstetric practice and sepsis (Loudon, 1992). Alternative theories are proposed by Symonds and Hunt, (1996), who assert that middle class women were often older having their first baby, so putting themselves into a higher risk category for complications.

For the majority of families living in the industrialised South Wales Valleys, ill-health must have been the norm, a legacy of poverty over a number of generations (Symonds and Hunt, 1996). A study of a South Wales area in the 1970s found that the general health of the population was poor (Robinson, 1971). Hart (1971) argued the case of the Inverse Care Law, where those most in need of services are least likely to get them. He found, however, that doctor – patient ratios in the South Wales Valley areas were good at that time, although expected to worsen. Other aspects, such as accessibility to services in the area were poor, and this would be

likely to lead to a decrease of the health of the local population. As Blaxter and Paterson (1982) found in their study of working class mothers and daughters in Aberdeen, the poor state of health which families suffered led them to view health in a negative way – from a position of illness rather than health. Being ill, however, sometimes worked in one's favour: Parsons (1952) in his seminal work which explored the sick role, pointed out that illness gave special privileges, especially when supported by the medical profession. The usual role within the family and work was modified, with support given from family and friends. This view of the '*sick role*' meant that people were exempt from their normal social responsibilities, needed to be taken care of, and relied on medical expertise to enable them to become well.

The aura of ill health and the influences of medical staff over the daily lives of people may have contributed to the culture of being 'under the doctor' which could be observed for many years, and which still exists in some elderly people in Cwm Fechan today. As Symonds and Hunt (1996) suggest, people become the product of their cultural and historical surroundings, fitting into the parameters of their society at that particular time.

In the 21st century, conditions in Cwm Fechan have changed from those described in the valley's history. There are new housing developments, and community regeneration schemes to improve an environment dominated by the former coal industry. The valley has never looked prettier, with trees and green fields replacing coal tips and mine workings, but these are superficial changes that can mask the underlying issues that still dominate local communities. There continue to be high levels of economic inactivity, poor job opportunities, low educational achievement and a high incidence of health problems. These are issues which only sustained economic investment into the area can address, but recognised by the Welsh Assembly Government in its 15 year regeneration proposal for the Heads of the valley's area – *'Turning Heads…A Strategy for the Heads of the Valleys 2020'* (WAG, 2006b). This is a programme for investing a billion pounds in sustainable development, to improve the quality of life for the people who live within the five local authorities of the area, including Cwm Fechan.

## 4.2 The Medical Model of Care

The medical model is a term used to describe the view of health and disease that has predominated in the West over the past 200 years. The medical model is claimed to be a social construction that has developed during the historical and cultural influences of this time (Wright and Treacher, 1982; Levinson, 1998; Bilton *et al*, 2002). Jordovana, (1995: 361) explains how *"It has not proved possible to formulate a neat definition of social history of medicine",* suggesting instead that social constructionism provides a way in which the relationships of medical knowledge and their historical context have changed over time. Some of the key elements of this process will now be discussed.

During the 18th century, the medical profession began a period of rapid development, and in contrast to previous philosophies that centred on traditional beliefs about the world, medicine began seeking to control and improve on nature (Doyal, 1991; Bilton *et al*, 2002). Throughout the period of industrialisation, the power of the doctor increased. Doctors were required to make a judgement about illness and health, which could directly affect the economic values of the time (Kennedy, 1983). At the same time, a mechanistic view of the human body became an accepted principle in the growing medical profession, (Bury, 1998). Women were viewed as inferior to men both intellectually and physically. They were believed to be irrational and illogical beings, controlled by the process of reproduction and unable to reach the levels of knowledge obtained by men (Scambler, 1998). Science was thus equated with a masculine viewpoint, which Donnison (1988) suggests led to today's medical (masculine) model of care. An alternative view, proposed by Oakley, (2000), purported that women were not simply excluded from science or education, rather, a cultural shift meant that science was equated with men: women were perceived as being passive. Harding (1991) described this action as androcentric, rather than sexist. Hardyment (1994) takes the view that it was the domestic concerns of women that blocked their opportunities for education and work. Whatever the approach taken, there was a general agreement between these different views that these attitudes have shaped the way that science and medicine still continue today.

At the beginning of the 20th century the medical model adopted a view of disease, which was based on objectivity, and the growth of scientific principles (Lawrence, 1995). From being a machine, a person was now seen as an object: a body rather than an individual (Goldberg, 2002). This was enhanced by the practice of the clinical medical examination. As Armstrong (1982: 110) maintains:

> *"The hospital, with the visibility and access it gave to clinical bodies, became the cornerstone of medical care and the clinical examination, as the process which objectified individual bodies became the fulcrum of clinical practice."*

The introduction of the National Health Service in 1948 ensured that everyone, regardless of income, had access to free health care from a variety of professionals. This gave all women and children access to medical care that had previously been lacking for those who could not pay. The way in which the NHS was organised however, gave the medical establishment almost free rein over the way in which care was provided – concentrating on the medical model of care (Ranade 1994). Paternalistic attitudes prevailed in the NHS; Jones (1994) described how the Doctor / Nurse / Patient relationship was equated to the Father / Mother / Child stereotype, based on Victorian values: the father always dominant, therefore always right, the mother and child subservient. For women from mining communities, this was the norm. They lived in a male dominated society where men worked and socialised together; women were an invisible part of this culture (Symonds and Hunt, 1996).

The medical model of care today can sometimes be seen to adopt a reductionist viewpoint, where the focus becomes concentrated on the physiological processes, rather than considering other elements which may affect health such as social and economic factors (Kent, 2000). This reductionist view can be observed in the way that a state of health is perceived to result from treating sickness rather than preventing it, (Kennedy, 1983). In this model, medical knowledge is believed to be superior to the information provided by the person, which is often ignored or discounted as incorrect (Kent, 2000). This has been shown in the way that health personnel treat patients differently, with those in higher social classes being afforded more time and explanation (Bilton et al, 2002); men are taken seriously, whilst women are considered to be neurotic when they present with the same complaint (MacIntyre and Oldham, 1977). Doctors have power in these exchanges, as their clinical judgement presides over who will receive medication or medical certificates

(Kennedy, 1983). Emphasis is placed on the pathology of disease, the scientific knowledge and specialist roles that are used in diagnosis and treatment (Jones, 1994). Although the doctor has a key role in this model, many other health professionals are involved, as much of the care is carried out in hospitals or medical clinics (Bilton *et al*, 2002). As the medical model has come to dominate health care, its values and beliefs have become accepted as the norm: the way from which illness and health is viewed (Levinson, 1998). Kennedy, (1983), attributed the blame on Doctors for cultivating this dependence on the ill health culture, and argued the case for health promotion and the prevention of ill health. Twenty years later, health policy is beginning to reflect this position (for example Wanless, 2002; WAG, 2003, 2006a).

### 4.2.1 The Medicalisation of Childbirth

In the NHS, the care of pregnant women became the province of the hospital-based obstetrician. Hospital based antenatal care was provided for all women, and hospital births increased; almost all births taking place in hospital from 1970 onwards, (McFarlane, 1984), although accurate figures are difficult to determine, due to changes in the way that data has been gathered over the years. In doing so, childbirth became associated with the medical model of care, viewed from a pathological viewpoint (Cahill, 2001) and giving rise to the theory that birth was only normal retrospectively. There were a number of factors that contributed towards the move to a more hospital-based service. Oakley (1984) argued that antenatal care was introduced to exert a social control over women, but also felt that women attending for antenatal care in hospital were more likely to have their babies there. Symonds and Hunt (1996) attributed the increase in hospital birth to women wanting access to pain relief in labour.

Doctors began to establish a monopoly over maternity health care (Donnison, 1988, Oakley, 1984, Doyal, 1991, Jones, 1994). This was seen in the argument for hospital being the safest place for birth, widely accepted and used to determine government policy in the UK, for example in the *Peel Report* (Peel Committee, 1970). Tew (1985) argued against this belief, and demonstrated by an analysis of published surveys and statistical records that giving birth in a consultant obstetric unit was linked to higher stillbirth and perinatal mortality rates, even when allowances for higher risk patients and complications were factored in. Feminist writers including

Oakley, (1980, 1984, 1986), Doyal (1991) Harding (1991) and Bilton *et al*, (2002), have discussed the ways in which female reproduction has been controlled by medical staff, with birth becoming more regulated and mechanised as technological advances such as fetal monitoring were introduced. Women became increasingly dissatisfied with the maternity services, leading to what Oakley (1986: 236) labelled as the *'Consumers' Revolt'.*

In the 1970s, women began to voice their dissatisfaction, and consumer pressure groups such as AIMS (Association for the Improvement of Maternity Services) began to campaign for the normalisation of childbirth, and for better treatment for women. Comments from women, published in one of the group's newsletters, showed how they felt they were treated at antenatal visits (AIMS newsletter, Summer 1980: 1)

> *"Cattle-markets, of block booked appointments and long sordid waits for a brief prod by a stranger (different each visit) who is hostile to women's questions about their own bodies."*

Although the process was slow to move towards care that treated the woman as an individual who has opinions, plans and ideas of her own about how her birth should be managed, the idea of developing a model of care based on normal childbirth eventually began.

### 4.3 Woman-centred Care

The debate surrounding the provision of maternity care continued into the early 1990's, culminating in the Welsh Health Planning Forum's report *Maternal and Early Child Health* (WHPF 1991), and the *Changing Childbirth* report of the Expert Maternity Group (DoH, 1993). *Changing Childbirth* advocated that a woman should be given the opportunity to make informed choices about the care that she would receive and by whom this would be provided, and be able to participate actively in the decision making process of any or all of her care.

The provision of woman-centred care required a philosophical and organisational change in the way that maternity care was provided, the care being arranged to suit the needs of the woman, rather than those of midwives and obstetricians, as suggested by McCourt *et al*, (2006). Choices for care needed to be made available,

the concept of a named midwife and continuity of care was to be implemented, and to enable the woman to make choices, she needed to have access to unbiased information, with a concomitant shift of power from the professionals. Services were to be based on the needs of the local population, and easily accessible to all users. These were stimulating ideals, embraced by some and rejected by others (McCourt *et al*, 2006), but importantly, from a midwifery perspective, women centred care offered the chance for the midwife to become the lead professional for women who had normal pregnancy, thus regaining her tenure over normality, with the trade-off of giving the obstetrician more time to spend with those women who had complex health needs. Their complementary roles would ensure that a woman had the type of care that was most appropriate, beneficial, and centred on her individual needs.

For those NHS Trusts who embraced the ideals of midwifery-led care, services were provided in various settings, but aimed to provide a friendly atmosphere and a flexible service tailored to the needs of women and their families. Some women therefore had the option of giving birth away from a medicalised environment although on an individual basis this was limited by availability of services and factors such as health and obstetric history (Kirkham & Perkins, 1999). For some women however, service developments did offer a wider choice than was available previously. In the UK, GPs often provided maternity care for women, with access to beds in obstetric units or small community hospitals. These services, popular in many areas in Wales during the 1970s to the 1990s, had been in a gradual decline, and were in some instances augmented or replaced by midwife led services (Zander & Chamberlain, 1999). Fortunately for Cwm Fechan, The *Maternal and Early Child Health* report, (Welsh Office 1991) and *Changing Childbirth* report (DoH 1993) had arrived at a politically expedient time for maternity services in the valley, and facilitated the way for the birth centre.

### 4.4 The History of Cwm Fechan Birth Centre

In Cwm Fechan, GP and obstetric-led maternity services were provided in a purpose built unit in the local General Hospital. Following a number of health service reviews, two separate health districts each with its own maternity unit became amalgamated. Over time this led to a sharing of senior medical and other emergency

staff between locations, a situation which was occasionally impractical, and more importantly, against the advice of the obstetric and paediatric Royal Colleges. A new addition to the larger District General Hospital (DGH) in one of the valleys was built to provide a full range of obstetric and paediatric services to replace the older hospital there. Medical staff, wishing to centralise their facilities on one site, began a planned erosion of services from the second maternity unit, in anticipation of its eventual closure. Births were shown to have decreased from approximately 700 per year up to 1990, to less than 100 in 1994 according to the obstetric unit's birth statistics.

*Changing Childbirth* (DoH, 1993) reinforced the recommendations of the Welsh Health Planning Forum (1991) at what was a politically sensitive time for the Local Health Authority. They decided that the offer of a birth centre, providing the facility for normal births, might allay the anticipated public outcry if all maternity services were moved to the District General Hospital (DGH) seven miles away in another valley. Although women have always had the option of giving birth at home, this too had been gradually declining to reach less than 1% of all births in 1987 (Davies *et al*, 1996). There were very few planned home births in the study area (less than one per year) and home birth is not usually an option for women with complex health needs who have care with an obstetrician.

The views expressed in several public meetings which myself and other midwives attended were that this option had been put forward to take the heat off the closure of the obstetric unit, but the plan did have some local support from the public, from midwives who wanted to work in a midwife led environment, and from the few local General Practitioners who traditionally had provided maternity care within the Unit. It is difficult to imagine today what an innovative idea the birth centre was when it was initially proposed, but meetings were staged to give staff legal advice and answer questions, later published by Dimond (1994), and an expert midwife was employed to give support in the early stages (see appendix 4).

A multi-professional steering group supported by the (then) Welsh Office was established to oversee the transition, although no one really expected the birth centre idea to reach fruition, much less become successful, according to one local GP who

was rather surprised to have a visit from the birth centre manager to confirm its opening (personal communication). I was invited to take part in the steering group as a clinical midwife representative. The steering group, originally nine members comprising medical, midwifery and strategic administrative staff, reduced to four as the project gathered momentum (see appendix 5). The birth centre manager, myself, a local GP and the Head of Midwifery remained, but the nominated obstetrician and paediatrician on the group resigned as they felt that the concept was unsafe. They were not willing to give any support, advice or help at that time[7]. Minutes of the meetings showed the negativity with which all but a few professionals received the idea of a midwife led unit, with a haematologist (Dr M, a co-opted member for specialist advice), openly stating that his (medical) colleagues were opposed to the birth centre in Cwm Fechan, although would support its development on the DGH (see appendix 5). There was much discussion about the viability of the unit, as no market research had been undertaken to see if there was an actual demand for this type of service. Obstetricians and members from the Health Authority were of the opinion that women would not want to be cared for by anyone other than a doctor, an example of the stereotyping of women discussed by Green *et al*, (1990). As midwives, we feared this would be true, equally guilty of stereotyping, a legacy of working within the medical model of care.

Long talks were held on the financial cost of the Unit, which still surround debates over the viability of birth centres today (O'Sullivan and Tyler, 2007) but political expediency won the day; the Welsh Office had advocated the development of midwifery-led care and could now be seen to be supporting this step. The birth centre prepared for opening. Refurbishment was carried out during 1995, and the centre was opened for births in November of that year.

The birth centre was to be staffed by 12 midwives, with no specialist medical facilities available on site. Strict guidelines were developed by the Steering Group to ensure that women were offered prompt transfer to the care of an obstetrician in the

[7] After the birth centre opened, opinions changed, and midwives and doctors worked in close collaboration to ensure that women received appropriate care, with referrals to obstetricians from midwives for complex cases, and from obstetricians to midwives, where pregnancies were normal.

DGH, should any complication arise (see appendix 1). The guidelines were not able to be evidence based – there was no suitable evidence in publication at the time – so were pragmatic, based on common-sense and professional judgement by the three midwives and one GP in the later group. It was implicitly understood by the steering group members that activity in the birth centre would be subject to intense scrutiny particularly by obstetricians[8]. Some GPs were openly supportive, others less so, refusing to 'allow their patients' to go to the birth centre, under threat of removing the woman and her family from the GP list[9]. This problem was only surmounted by pressure from women, who would go and confront the GP, to ask why their choices were being limited in this way, a problem that persisted for several years.

However, the views of obstetricians, GPs and midwives changed over time. Initial suspicion, professional rivalry and fears over outcomes were replaced by acceptance and mutual respect, leading to a system of good collaborative care (see also, section 7.11.1). The same process that was observed in Cwm Fechan was been reported by Dougherty in 2008, following the legalisation of midwifery in Quebec [internet: http://www2.Canada.com/montrealgazette/news/story.html].

### 4.4.1 Changes Since *Changing Childbirth*

The birth centre today remains in an area of high social deprivation, characterised by low educational standards, poor quality housing, high levels of unemployment and high rates of teenage pregnancy (Bro Taf Health Authority, 2000), although there is beginning to be some regeneration of the area. Approximately 60% of all pregnant women in the area choose to go there for maternity care. Although care in normal pregnancy is provided by midwives, close working with obstetricians is an essential part of maternity care: complications arising mean that each year approximately one third of these women are transferred to the care of an obstetrician during pregnancy, with a further ten percent of those remaining being transferred in labour. These transfer figures have been consistent throughout the history of the birth centre, though the booking figures have increased (Birth Centre Statistics, appendix 2).

[8] Obstetricians requested an independent review of practice, which was carried out a few years later by an obstetrician and midwife consultant.

[9] One GP practice provided otherwise excellent GP care, but forbade primigravidae to go to the birth centre. Inexplicably, the same GP practice would 'allow' primigravidae to have a home birth.

Although embraced in full in this Trust, the response to *Changing Childbirth* (DoH 1993) has been mixed throughout the UK, with some areas adopting the philosophy more readily than others, particularly where choices for maternity care are concerned. Various assessments of the response to the report have been undertaken in the years since it was published. The Audit Commission's report *First Class Delivery* (Audit Commission 1997) stated that only one in three women felt they had a realistic choice about how their care was provided, and this situation had not improved ten years later (Beake and Bick, 2007). The report of the Standing Nursing and Midwifery Advisory Committee, (SNMAC 1998), indicated that there was an incremental move towards adopting women centred care, but that this had not happened in many acute trusts. The views of users of maternity services were explored by the National Childbirth Trust, (2003), who carried out a postal survey of NCT user-representatives in England, Wales and Northern Ireland who used maternity services between January 1998 to March 2001. The report demonstrated examples of women centred services that were provided across the UK, but showed that many initiatives that had started following the Changing Childbirth report, were no longer in operation due to financial or staffing constraints. The report (NCT, 2003: 28) concluded:

> *"That the recent changes in maternity services may have increased the medicalisation of care and access to screening and medical services considerably more than access to midwife-led care or opportunities to have a straightforward vaginal birth."*

Whilst the report discussed that user representatives were not always privy to recent information about services, the erosion of midwifery-led services was a cause for concern. More recent health policies in both England and Wales, for example the *National Service Framework for Children, Young People and the Maternity Services* (WAG, 2006a) remind us that women should be given choices about appropriate care and services available, and that care should easily accessible in the community, but it is noticeable that in section 3.2, midwifery-led care and units were not mentioned.

The background information about Cwm Fechan and the development of the birth centre was considered, together with questions arising from the preliminary literature review. This gave a better insight into what the research study should encompass, and how this should be carried out; the subject of the next chapter.

# Chapter Five: Research Methods and Study Design

This chapter outlines the way in which the study was designed and conducted, discussing and giving justification for the methods used. The chapter begins by discussing the aims of the study, then emphasises the need for the research: identifying where a gap in existing knowledge was found. The reason for choosing a qualitative research method is clarified, with an explanation given about the research methods that were considered and rejected before choosing the method to meet the aims of the study. The chapter goes on to explain the research strategies used, and the ethical considerations made.

## 5.1 Aims of the Study

Initially, the aim of the study was to establish why some women had voiced dissatisfaction with care when transferred from birth centre to nearby obstetric unit, as a result of complications arising in labour. General speculation amongst midwives gave several possibilities which might account for the dissatisfaction: the reasons for women choosing the birth centre were unknown as no research had been conducted to find out women's views, therefore nothing was known of women's expectations and how they related to their care. A significant minority of women had care transferred at some point (see appendix 2), and therefore had the potential for feeling disappointed or let down, but this had never been explored. The transfer journey in labour might be frightening to women – the ambulance journey took approximately 15 minutes, though organising transfer could take considerably longer, depending on the availability of the ambulance. This was an unknown entity.

Cultural and social differences existed between Cwm Fechan and the site of the DGH, with women favouring local services. This might influence women's views of their care. These points all seemed to be possible explanations, but these were the views of midwives, not of women using the service. Their expectations and experiences were needed to answer the initial aim of the study.

Questions that would find out the information were considered, and defined as aims of the study:

- To identify why women wanted midwifery-led care in a birth centre;
- To elicit women's expectations in the antenatal period and for labour and to explore their experiences of care;
- To conduct an in-depth study of the experiences of women who had a transfer of care from the birth centre to the nearby obstetric unit in late pregnancy or during labour.

## 5.2 Contribution of the Study

The literature review in chapter two emphasised that little was known of women's experiences of being transferred from midwifery-led to obstetric-led care during labour. The two UK studies (Walker *et al*, 1995 and Creasy, 1998), although concentrating on women's experiences of transfer, had different research parameters. In Creasy's (1998) study, the birth centre was within the DGH, so only a change of room was involved when care was transferred. In Walker *et al*'s (1995) study, the system of care was quite different from the birth centre, and some of the women interviewed had never intended to give birth there. This study would explore different aspects, with a group of women who had intended to give birth in the birth centre, but were transferred in the late antenatal period, or during labour, to obstetric care in the DGH eight miles away, thus affecting their expectations for labour and birth. Furthermore, information about local women's views of services would be obtained, which had never previously been sought. This would be able to make an original contribution to what was known about women's expectations and experiences of birth.

## 5.3 Research Methods

Research methodology was reviewed to ensure that the method chosen appropriately met the aims and fundamental aspects of the study, and could answer the research questions posed. For research to be regarded as meaningful, the methods used must be able to demonstrate effectiveness in the kind of knowledge produced, the underlying assumptions made, and the role the researcher played in the process. It would then be possible to assess how successful or otherwise the research had been at answering the research question (Willig, 2001). Another view was that the research design encompassed the entire process, from the underlying philosophy and

theory, collection and analysis of data, and the quality of the results that were obtained (Cresswell, 1998).

So, using the most appropriate research methodology, not only as a means to answer research questions, but to ensure that the research was of value was of the utmost importance. The process of research is time consuming – it absorbs the time of the researcher, of the participants, of the reader. It was vital that the research could withstand rigorous scrutiny and still be seen to make a positive contribution to the field of knowledge, and perhaps more importantly, for the well-being of women.

### 5.3.1 Qualitative Methods

In order to meet the aims, the study would need to follow a method of qualitative research. There was little known about the subject, therefore a method which sought to explore and describe the issues of women's expectations and experiences would be appropriate (Brink and Wood, 1989). There are many methods of qualitative enquiry: Miles and Huberman (1994) state there are dozens of ways of conducting qualitative research; Woolcott (1992) finds over twenty different types of research.

Methods such as ethnography or case study research were considered, as were discourse and content analysis. All of these methods had been used in social constructionist research (for example Hunt, 2004 used ethnography; Gergen *et al*, 2004, used discourse analysis). The focus of this study, however, was to explore women's expectations and experiences during pregnancy and childbirth, using social constructionism as a means to gain a perspective on women's views. As the investigation of research methods unfolded, the final choice lay between two methods: phenomenology and grounded theory.

### 5.3.2 Grounded Theory or Phenomenology?

Although these are distinct methods, confusion between phenomenology and grounded theory is not uncommon, (Corben, 1999) and is known by the term 'Method Slurring' (Baker *et al*, 1992). Both of the methods could be used to explore the experiences of women, but had the possibility to introduce researcher bias that would influence the interpretation of data, even though I would be as objective as possible (see Researcher Reflexivity, section 5.12). I needed to ensure that the

method chosen allowed for this eventuality, and if possible, that my existing knowledge would be advantageous, rather than the opposite.

### 5.3.3 Grounded Theory as Method

Grounded theory was a method established by Glaser and Strauss, (1967) in which theories were generated directly from data, and were therefore closely linked to the subject matter that was studied (Strauss and Corbin, 1990). A number of interviews were conducted with a group of participants chosen as a sample to help the researcher generate the theory, looking at how people "*act and react"* (Cresswell, 1998: 56) to certain situations. The number of participants was dependent on information gathered. When no more new information was gathered, data collection was considered complete. Information gathered from one respondent was used to inform the data collection from another, in an incremental way. A process of analysis systematically coded and recoded the data until concepts, and then theories were derived (Cresswell, 1998). Grounded Theory allowed the use of the previous knowledge of the researcher to gain an understanding of the social processes observed (Baker *et al,* 1992) though this could also lead to pre-empting the emerging theory (Cresswell, 1998).

Common problems associated with the use of grounded theory as a research method have arisen as a result of the process of research not being carried out in the prescribed way (Creswell, 1988; Strauss and Corbin, 1990), or the data collection being prematurely halted, before saturation of data has occurred (Streubert and Carpenter, 1999).

The studies discussed in the preliminary literature review (Walker *et al* 1995, Creasy 1997, see chapter 2) had used a grounded theory approach in which both theorised that it was important for women to retain an element of control over their situation, and that this could be achieved by being given enough information about their care. It would have been possible to use grounded theory to explore women's experiences of transfer, and what it was about that particular aspect that led to dissatisfaction – to discover what was influencing these women (Glaser, 1978). This would have been a replication of these studies, (in a different setting), but this research was intended to

cover many other aspects which might then contribute to dissatisfaction, rather than just the process of transfer.

### 5.3.4 Phenomenology as Method

Phenomenology is not just a single method of research. There are many different types of phenomenology that may be used, including those developed by Husserl, (1931); Heidegger, (1927); Gadamer, (1976); Merleau-Ponty, (1945); Ricoeur, (1976) and more recently, Smith (1996).

Phenomenology was first used to describe the experiences of people. The perceptions, explanations and analysis of these experiences depended upon the type of phenomenology used (Streubert and Carpenter, 1999). The method involved gathering data, usually in the form of an interview, later transcribed. Repeated readings of interview transcripts allowed the researcher to form an impression of what the experience was like for the individual, ensuring that all impressions were closely linked to what was said by the individual. Experiences were coded, and then incorporated into themes, finally translated from the verbal and verbatim transcript into a written form that captured the individual's meaning, rather than that of the researcher. For this to happen, the researcher needed to be able to communicate effectively with the participant (Reinharz, 1983). How codes were attributed, themes developed, and the written form processed were dependent on the type of phenomenology used.

In this study, what women expected from and experienced in their maternity care, and their feelings when they experienced transfer of care were the key to choosing the method. I felt this could only be achieved through a phenomenological perspective.

## 5.4 Phenomenology

In order to gain an insight into the various approaches, it was decided to first look at the historical perspective. This would enable my understanding of how the method of enquiry developed into one often seen within nursing research over the last 20 years, for example in studies by Smith, (1994), exploring how women's first pregnancy influenced their perceptions of themselves; Morrison *et al* (1999),

establishing how parents' perspectives on home birth were reliant on a mutual engagement between client and care provider; Gibbins and Thomson, (2001) who gained an understanding of expectations and experiences of primigravid women in the North of England; and Savage, (2001), who researched how first-time mothers learnt about the process of birth.

Understanding the origin of the methods was necessary to determine that this study was based on the phenomenological method, a term often used inappropriately according to Corben, (1999). An exploration of the subject was therefore undertaken to elicit which phenomenological approach was best suited to the proposed research.

### 5.4.1 The History of Phenomenology

A definitive history of phenomenology was written by Speigelberg, (1982), who detailed the development of phenomenology from the time of Plato to the 1980s. The following section draws on the work of Speigelberg, (1982), unless indicated otherwise.

Speigelberg emphasised how the Phenomenological Movement was fluid in nature, with individuals changing their ideas over time, as well as following different ideas at a tangent to the mainstream. The word 'phenomenology' was in widespread use by many disciplines in its early history though he suggests that Immanuel Kant applied the first usage of the word in a scientific context in a publication *(Metaphysische Anfangsgrűnde der Naturwissenschaft)* in 1786.

Modern usage of the word however started with Husserl, a late nineteenth century mathematician and philosopher. Husserl began what Speigelberg described as the development of phenomenology in terms of a geographical movement, beginning in Germany and moving through France, Italy, Spain, Latin America, Anglo-America, India and Japan.

Three methods of phenomenology were reviewed, tracing the early developments in the process of research.

### 5.4.2 Husserlian Phenomenology

Phenomenology was developed by Edmund Husserl (1859 – 1938) as a rigorous research method, which moved away from those used in traditional empirical research. Although frequently cited as the founder of phenomenology in the modern usage of the term, Husserl acknowledged the influence of his tutors and colleagues Franz Brentano and Carl Stumpf in developing his ideas (Cohen, 1987).

Husserl wanted to give clarity to basic concepts that had previously only been described in the abstract, thus giving a firm scientific basis to all disciplines, not only in the field of psychology with which he is most often linked (Ashworth, 2003). Husserlian phenomenology was drawn only from the information presented - the 'things themselves' (Paley, 1997). Husserl proposed that the researcher must acknowledge and set aside his or her own beliefs and ideas, reproducing only descriptive data which 'tells how things are' for the subject (Koch, 1996). However, this presented a philosophical problem - there would always be the conscious experience of the researcher to be taken into consideration (Stewart and Mickunas, 1990).

Husserl decided that by using a process, known as '*bracketing*' the researcher would recognise, acknowledge and set aside presupposition and assumption when undertaking phenomenological research. This would leave only the experiences described by the subject, rather than the interpretation of the experience by the researcher, (Ashworth, 2003). The researcher would then go on to produce a descriptive statement of data, capturing the 'essence' of the experience. This was a naïve description of the event (Giorgi *et al*, 1975). The process of bracketing formed the pivotal part of Husserl's phenomenological method (Bartjes 1991), as this meant there was no subjective interpretation by the researcher, (Ashworth, 2003). Bracketing was always a conscious effort applied through all parts of the research, not only used during data analysis, however this was a difficult process. A lapse of concentration could mean the unwitting introduction of the researcher's own agenda into an interview so interfering with the process of exploration of the lived experience of others (Beech, 1999). This type of phenomenology was sometimes referred to as eidetic or descriptive phenomenology (Fleming *et al*, 2003).

### 5.4.3 Heideggerian Phenomenology

Martin Heidegger (1889 – 1976), a former student of Husserl, introduced the use of interpretation in phenomenology, taking the opposite stance to Husserl. Heidegger felt that a person could not help but use his or her own experiences in the interpretation of information; he claimed that this was an intrinsic part of being human, thus introducing the concept of hermeneutics in phenomenology. In his view, reality is not passively observed by human beings, but is subjected to finding explanation and meaning in all that is observed (Magee 1987).

The Heideggerian view of the person, existing in a point in time, had five main points. The person has a cultural and historical place in the world which can be taken for granted and therefore overlooked; understanding a person can only be achieved by seeing them in context; the person develops their own sense of understanding of self; experiences occur through interaction with the world; the person exists in a given time frame, but time is a linear concept, moving through past, present and future (Leonard, 1994)

The essence of Heideggerian phenomenology was on understanding experiences, rather than describing them in the way of Husserlian phenomenology (Cohen and Omery, 1994). Heidegger, however, did not carry out psychological research like Husserl, but instead followed his own line of philosophical research into time and spatiality. One of Heidegger's greatest contributions to phenomenology was his influence on the French Existentialism phase of the Movement, (Cohen, 1987), and indeed, this type of phenomenology is often referred to as '*existential phenomenology*' (Koch, 1995).

### 5.4.4 Gadamerian Phenomenology

Hans-Georg Gadamer (1900 – 2002), following on from Heidegger, further developed the notion of hermeneutics, to include the way in which a phenomenon was understood. Rather than the Husserlian philosophy which required all pre-existing knowledge to be set aside, Gadamer advocated that using the researcher's existing knowledge and experience to interpret data would make the research more meaningful (Koch, 1995). In addition, the researcher would need to actively seek to develop new meanings and ideas about the data that were outside their own

experiences. This had a two-fold purpose: to expand the researcher's personal insight of the subject in hand and to realize a common level of understanding with the participant. Gadamer felt the notion of being able to present 'the things themselves' (Husserl, 1931) during interpretation was not possible, as the observer would always be influenced by their own experiences. However, by achieving what he described as a 'fusion of horizons' through exploration of a shared linguistic understanding, and that by knowing the historical context and background of the participant, a common grasp of the experience would be achieved (Gadamer, 1976). This notion of social and historical understanding of the participant is congruent with social constructionism, discussed in chapter three. Gadamer depicted the process of understanding as being part of a 'hermeneutic circle' in which gaining an understanding of the detail would enable the whole to be understood, and that this in turn would augment the understanding of the detail: a cyclical and dynamic process. Gadamer (1972: 267), suggested that *"Working our appropriate projections, anticipatory in nature, to be confirmed 'by the things' themselves, is the constant task of understanding".*

Gadamer, in common with Husserl and Heidegger however, did not describe the specific methodology for carrying out phenomenological research (Wood and Giddings, 2005), so although a hermeneutic philosophy addressed many of the issues that arose in using phenomenology as the research method in this study, further clarification of the method was sought.

### 5.4.5 Understanding the Phenomenological Method

All research has its own terminology, which helps to define and illustrate the differences between one method and another. The use of research terminology is essential to gain insight and understanding of the research process, but the use of specific terminology may have inhibited the publishing of nursing research in the past and have led to a lack of understanding of the research process, (Cormack, 1991). Two opposing viewpoints on the use of terminology in phenomenology were found that served to illustrate Cormack's (1991) point: Stewart and Mickunas, (1990) acknowledged a bewildering use of terms, and said these were necessary to give clarity to the research and avoid philosophical assumptions which might

otherwise arise. This was countered by Paley, (1977) who suggested that phenomenological concepts were often misunderstood due to difficulties in translation, and were therefore misquoted and used without justification by nurse researchers.

Phenomenology arose in Germany, and the seminal papers were published in German, some later translated into English. The use of specific terminology meant that the meaning of some of the research terms used in the original texts were lost in translation (Corben 1999). Thus, German words[10] such as 'epoche', (literal translation epoch), 'dasein' (presence or existence), and 'lebenswelt' (lifeworld) held ambiguous meanings for the researcher. The use of terminology implies that the author is knowledgeable about the fundamental principles of phenomenology, and it may be that the use of the jargon is in itself an 'appeal to authority' giving credence to what is written (excluding and intimidating the less knowledgeable reader) without being substantiated by the research process.

The difficulty of searching amongst the many types of phenomenology for a method to use was addressed by the development of a seven-step account of what a phenomenological method might look like (Speigelberg, 1982: 682):

1. Investigating particular phenomena;
2. Investigating general essences;
3. Apprehending essential relationships among essences;
4. Watching modes of appearing;
5. Watching the constitution of phenomena in consciousness;
6. Suspending belief in the existence of the phenomena;
7. Interpreting the meaning of the phenomena.

There was a lack of agreement between researchers, however, about how a phenomenological study would be conducted. One author felt that phenomenological processes had the potential for being misunderstood, with the

[10] Translated from the Collins Gem German / English dictionary, 1978

nuances of the method being lost when original works were translated from German to English (Paley, 1997). Other views suggested that the method would be compressed into four stages: bracketing, intuiting, analysing and describing (Oiler, 1982); that there was no specific list of procedures to follow (Annells, 1996); or that research methods differed according to which author one read (Sadala and Adorno, 2002). A more idealistic view suggested by Omery (1983: 53) was that:

> *"Most researchers in the social sciences who have advocated or implemented the phenomenological method have been inspired by it, rather than directly applying steps".*

This, however, was a difficult concept to apply to my own study. As an inexperienced researcher, I felt I needed a more defined approach to the research. This was a common requirement shared by others in similar health care professions, (Omery, 1983). For me, the element of uncertainty surrounding the process was encapsulated by Munhall (1989: 165) who stated:

> *" For most of us, a "where to begin" and a "how to do it" frame our thinking and help us actualise the concepts and beliefs underpinning the method".*

### 5.5 Hermeneutic Phenomenology as Method

Phenomenology, and, in particular hermeneutic phenomenology are methods often used in health care research (Holloway and Wheeler, 2002). To gain both knowledge and inspiration about the method, I planned to review a number of phenomenological studies. A similar review was undertaken by Streubert and Carpenter (1999) in which they summarised the discipline, method, phenomena under review, sample, data collection method and findings. In contrast, I intended to concentrate on the research methods described, in order to develop the methodological design of this study. I chose hermeneutic phenomenology, following the principles of Heideggar and Gadamer as I felt that this philosophy was the best approach to meet the aims of the research: it addressed the need to explore and make sense of women's experiences, but included using my own knowledge of pregnancy, labour and birth.

A search of full text articles published since 1999 was carried out to explore methods of data analysis commonly used in hermeneutic phenomenology. Databases used were *ALT HEALTHWATCH, MEDLINE, CINAHL and CINAHL PLUS,* using the search terms 'phenomenology / data analysis / midwifery / nursing'. Twenty-three

studies were found, describing a variety of phenomenological influences and methods of data analysis, of which 14 used a hermeneutic approach. Nine followed the hermeneutic influences of Heideggar or Gadamer (see table 4).

### 5.6 Models of Data Analysis

It was anticipated that a review of the research studies outlined in table 4 would help to clarify which model would be appropriate to adopt for data analysis in this research. The use of an '*understandable process of enquiry'* (Annells 1999: 5) was a feature that I sought to identify in the studies. However, one study that was carried out by Adolfsson *et al,* (2004) did not include details of the method of data analysis, a situation not uncommon in qualitative research according to Attride-Stirling, (2001). This study was therefore excluded from the review. Studies by Little, (1999); Atsalos *et al,* (2001); McCormack, (2003); Miller, (2003); Morgan, (2004); Shepherd, (2005); Cassidy, (2006) and van der Putten, (2008) showed six different methods of data analysis and are considered in the following sections.

**Table 4**
**Studies using Hermeneutic Phenomenology and Methods of Data Analysis**

| Author | Date | Publication | Phenomenological Influence | Method of Data Analysis |
|---|---|---|---|---|
| Little | 1999 | The Meaning of Learning in Critical Care Nursing: a Hermeneutic Study | Heidegger | van Manen |
| Atsalos *et al* | 2001 | The Lived Experience of Clinical Development Unit (Nursing) Leadership in Western Sydney. | Heideggar / Gadamer | Walters / Deikelman |
| McCormack | 2003 | A Conceptual Framework for Person-Centred Practice with Older People | Gadamer | Conversational Analysis |
| Miller | 2003 | Analysis of Phenomenological Data Generated with Children as Research Participants | Heidegger | Colaizzi |
| Adolfsson *et al* | 2004 | Guilt and Emptiness: Women's Experiences of Miscarriage | Heideggar | Not Specified |
| Morgan | 2004 | Using Clinical Skills Laboratories to Promote Theory-Practice Integration During First Practice Placement: an Irish Perspective | Heideggar | Giorgi |
| Shepherd | 2005 | Symphysis Pubis Dysfunction: a Hidden Cause of Morbidity | Heideggar | Colaizzi |
| Cassidy | 2006 | Student Nurses' Experiences of Caring for Infectious Patients in Source Isolation, A Hermeneutic Phenomenological Study | Gadamer | Thematic Analysis |
| van der Putten | 2008 | The Lived Experience of Newly Qualified Midwives: a Qualitative Study | Heideggar | Colaizzi |

### 5.6.1 Models used with Heideggerian Phenomenology

It was apparent that the most often used method of data analysis with Heideggerian phenomenology was that proposed by Colaizzi (1978). This consisted of a seven-step approach that began by reading through the transcribed text as a whole, to gain familiarity. What Colaizzi described as 'significant statements' were then extracted and used as a basis for developing meaning (steps two and three). In step four; the meanings were themselves developed into themes that were grouped according to similar meanings. These groups were categorised (step five) and used as a basis for producing a complete description of the phenomena they represented (step six). This allowed the essential structure of the phenomena to be identified and written about in a meaningful and understandable way, which could then be verified by the participant; the seventh step. In three of the studies using Heideggerian phenomenology Colaizzi's method of data analysis was chosen as it was felt by all authors that this provided clear steps to follow.

Miller (2003) explained that an understandable method was important to her as a novice researcher. She interviewed a group of children with Diabetes Mellitus to explore aspects of the care they received from community nurses. The primary focus of the reviewed publication was to demonstrate how the research process was followed. A clear and detailed outline of the rationale for the method and each of the stages involved was presented, providing a valuable insight into this aspect. Interestingly, the final stage of validation with the research participant was not undertaken, due to her research being concluded during the summer holiday period with many of the children being on holiday. Instead, Miller posted her findings to the participants and invited comments to be returned. As she received no contradictory views, she assumed that her interpretation was accepted. Although this was a pragmatic solution, no other means of validation was demonstrated, which was, I felt, a major weakness of the study, even though Miller explained that she had met with many of the families at a later date, and they informed her that they were in agreement with her interpretation.

Shepherd (2005) used phenomenology and Colaizzi's method to describe the experience of suffering Symphisis Pubis Dysfunction (SPD) during pregnancy and the post-natal period. She felt that this method was an efficient way of collecting and

analysing data. As in Miller's study (2003), the stages used for data collection and analysis were clearly outlined, and included the final step of validation of data interpretation by the participant. Four main themes resulted from the study: pain; lifestyle adaptation; emotions; and health professional's support and information. Each theme was illustrated with verbatim quotations from participants, which supported the thematic development and discussion.

Van der Putten (2008) evaluated issues that were found to be important to newly qualified midwives in their practice. Again, Colaizzi's method was chosen as it provided a logical and credible way of carrying out data collection and analysis. Six themes were identified in the study, which were common to all participants: reality shock; feeling prepared; living up to expectations; theory-practice gap; clinical support and mentorship; and continuing professional development. Again, themes were supported by verbatim quotations. It was noted that the study was small scale, and confined to one hospital, therefore the author acknowledged that generalisations could not be made. However, valuable information was obtained, which enabled the conclusion to be made that there was little existing research into the experiences of newly qualified midwives in Ireland, and suggested some areas where developments could be made, for example, by establishing closer links between education and clinical practice.

The two studies by Shepherd (2005) and van der Putten (2008) focussed on the research findings, therefore had less information on operational aspects than the study by Miller (2003). All three studies, however, gave a clear outline of the way that Colaizzi's method was applied to the collection and interpretation of the research data, and the reasons why this method was chosen. Three other studies also followed a Heideggerian approach, but used different methods of data interpretation. Van Manen's (1994) method followed a more philosophical rather than practical approach. He suggested that there should be six activities undertaken with research: to engage with a phenomenon that is of interest to us within our own sphere of knowledge; investigating the experience as lived, rather than perceived; reflecting on themes which characterise the phenomena; describing the phenomena through writing; maintaining the human relation to the phenomena, and considering the whole and the parts, in order to provide a balanced view.

Little (1999) carried out a study of nurses working in intensive / coronary care, who had recently undertaken recent post registration education in their speciality. She wanted to explore the meaning of learning for this particular group of nurses. Ten nurses who were employed in, or worked on a rotational basis in an intensive care unit were interviewed. A complex hermeneutic analysis was described, with over 50 themes initially being discovered. Regrouping of these themes to include only those shared by two or more participants was undertaken, and then further reduction took place by including themes with similar descriptions. Ultimately, three related themes were described: learning as focussing; learning as questioning; and learning as technological mastery. Only the final theme was common to all participants.

Little (1999) described how using a Heideggerian approach involved the researcher in all levels of data analysis, and acknowledged that although there was a philosophical framework associated with phenomenology, there was not a prescribed method to be followed. Little (1999) used the data analysis methods based on those described by van Manen (1994), but augmented this with other approaches when it was considered to be more appropriate. She explained the way in which she was able to follow van Manen's outline by a process of personal reflection, personal experiences, literature reviews and ongoing discussions with colleagues. The discovery of a single theme common to all texts, the mastery of technology, fitted with the method of Diekelmann *et al* (1989) who suggested that where a theme occurs throughout all the texts studied, this would be considered to be a significant or 'constitutive pattern'.

Giorgi (1985) described a six-stage model to be followed, which had similar aspects to both Colaizzi's and van Manen's method. In Giorgi's model, the texts are read through, and 'meaning units', rather than 'significant statements' marked. Each meaning unit is explored to identify how this relates to the phenomena. From this, general structures of the experience can be presented, and concepts developed. In the study by Morgan (2004), Giorgi's method was used to analyse data from a phenomenological study exploring student nurses experiences of their first practical placement in a large Irish teaching hospital. A clear exposition of the process of data analysis was presented. The study found that students were able to link theory with practice, by utilising information and practical skills learned prior to their placement.

Morgan supported this finding with several quotations from the texts, and discussed their relevance to existing literature and research.

### 5.6.2 Models used with Gadamerian Phenomenology

Atsalos and Greenwood, (2001) explored the experiences of leaders of clinical nursing development units, recently established in Western Sydney, Australia. The study found that the expectations and experiences of leaders changed over time, and that pressures of work, high staff turnover, unrealistic expectations and poor management support created stressors that affected motivation and confidence.

The phenomenological method was discussed in relation to gaining understanding of what it meant to be clinical leader in that situation. The researchers identified how they used a method adapted from that of Walters (1995) and Diekelman (1992), using a computer programme to identify themes which were then explored in relation to the hermeneutic circle discussed in section 5.4.4. The method used was compressed into three stages: reading the interview text several times to gain understanding; analysing for themes using the computer programme; identifying common themes by a process of comparing and contrasting the themes which emerged. Again, the concept of the hermeneutic circle was used in gaining understanding.

McCormack (2003) carried out a Gadamerian phenomenological study, using a process of conversational analysis and reflective conversation. This enabled him to develop a conceptual framework to enable person-centred practice when caring for the elderly. The study explored the meaning of autonomy for hospitalised older people, through recorded conversations and discussions between nurses, patients, and other members of the health care team. The researcher chose conversational analysis as a structured method of deriving interpretative themes from the data. Conversational analysis studies the interactions that take place between people through the medium of language, analysing how dialogue develops, rather than what was actually said (Wooffitt, 2001). Themes derived from the analysis in this study were clarified between researcher and participants to gain consensus and ensure mutual understanding, and thus served as a test of rigour. The study enabled factors

such as the patient's values and the context of the care environment to be identified as important aspects in providing patient centred care.

In the final study by Cassidy, (2006) thematic analysis was utilised as the method of data analysis and interpretation. The researcher identified the philosophical approach as Gadamerian hermeneutics, chosen as she wanted to explore collective experiences of student nurses caring for patients with infections, nursed in isolation. Cassidy described the use of thematic analysis as: transcribing interview data; immersion in the data by reading and re-reading transcripts and noting any patterns and meaningful comments; as analysis progresses, merging comments into similar groupings (described as 'aspects') groupings being further developed into themes which portray the participant's experiences.

The method of data collection was taped and transcribed interviews with eight students. Cassidy validated her research by asking the students to verify her findings.

Four themes were found which described the student's experiences: the organization: caring in context; barriers and breaking the barriers; theory and practice; and 'only a student'. The themes were presented and supported by verbatim quotations that illustrated the thematic analysis. A discussion was accompanied by a review of the relevant literature. The use of thematic analysis seemed to offer a flexible approach to data analysis, which broadly encompassed other methods, by becoming familiar with the transcribed interviews, and organising and reorganising sections of data until meaningful themes were identified.

### 5.7 Choosing the Research Method

The review of the studies using Heideggerian and Gadamerian approaches to phenomenology was undertaken to clarify which method for data analysis I wanted to adopt for my study. Having reviewed the six methods, I was able to exclude conversational analysis, as this did not fit in with the planned design of the study. Van Manen's method seemed daunting, requiring a comprehensive understanding of the philosophy that underpinned the method of analysis. In this regard, I agreed with Miller (2003) who felt unsure how to make use of van Manen's six-stage approach.

Colaizzi's method was clear, but the last stage of his method, returning to the participant to validate the phenomenological analysis did not resonate with some aspects of Gadamerian phenomenology as the researcher aims to develop their own understanding of phenomena, which are grounded in the experiences of the participant, but which do not seek to reproduce the participant's point of view (Walsh, 1996; Pascoe, 1996).

It was found that most studies used a loosely applied approach to data analysis, regardless of their stated chosen method. Most articles lacked detail on data analysis, as their focus was on presenting the research findings, rather than dwelling on methodology, a situation also described by Tuckett (2005). Methods were often combined; a relaxed approach which did not seem to affect data analysis. Supporting the findings with verbatim quotations, and the researchers' explicit knowledge of the subject matter made research findings appear credible. All methods used some form of categorising data from transcripts of interviews with participants. Analysis of transcripts produced information that was grouped into themes, and eventually compressed into manageable proportions to enable discussion.

As there did not seem to be one method which met all requirements when using hermeneutic phenomenology, it was decided to use thematic analysis, as this seemed to be a more straightforward and intrinsically flexible approach to data analysis. As Willig (2001: 21) says:

> *"Strictly speaking, there are no 'right' or 'wrong' methods. Rather, methods of data collection and analysis can be more or less appropriate to our research question"*

### 5.7.1 Thematic Analysis

Gaining an overview of thematic analysis was the next objective, however, it was found that there was disagreement between authors about the definition of thematic analysis. Boysatzis (1998) felt that it was a tool that could be used for data analysis in many different research methods within both quantitative and qualitative analysis. Other authors viewed it as part of a coding process within methods such as phenomenology or grounded theory (Morse and Field, 1995; Ryan and Bernard, 2000) or a method in its own right (Braun and Clarke, 2006).

Boyatzis (1998: 1) described thematic analysis as a "*way of seeing*", but noted that this insight depended on the perspective of the viewer. Boysatzis (1998) in his seminal work *"Transforming Qualitative Information: Thematic Analysis and Code Development"* suggested the process had three main stages: recognising (or seeing) a pattern in the text; recognising this as 'something' which can be coded; then developing this code to a theme which captured the essence of the observation. A fourth stage, that of applying interpretation to the theme to contribute to the development of knowledge might also be used. This method relied on the ability of the observer to be able to recognise something of significance in the text, which would happen as a result of being open to information, and by familiarity with the data. It was important that the observer's own views or perceptions were not projected on to the data analysis, although it was acknowledged that useful projection could occur, where an understanding was obtained through language between researcher and participant. (The equivalent of Gadamer's 'fusion of horizons'.) To ensure that the coded data were meaningful, it was necessary that they communicated the essence of the theme, were applied consistently to texts, and were supported by raw data. Clusters of codes could be formed to organise the themes into larger categories. He advocated discussion of the themes with others to obtain their views. Finally, it was suggested that the units of coding and the process of analysis and interpretation should be made clear. By following this process, a criticism of thematic analysis made by DeSantis and Ugarriza, (2000), could be avoided. They found that the notion of 'theme' was poorly defined in a review of 210 qualitative nursing research articled published in refereed journals between 1986 and 1988.

Although Boysatzis' process was comprehensive, I preferred the *"relatively straightforward form of qualitative analysis"* described by Braun and Clarke (2006: 94). Their six-phase method, shown in table 5 gave a clear outline of the process to be followed. This was the method chosen for the study. I also intended to adopt the definition of a 'theme' proposed by Streubert and Carpenter (1999), who described this as part of the process of data analysis, where a name is given to a cluster of ideas that represent a unit of meaning. This could be further defined as 'something that appears important to the research question' (Braun and Clark 2006).

This method, although similar to that of Boysatzis (1998), was less prescriptive, yet gave a well-defined, step-by-step account of the process including the presentation of the research findings. The method is considered in relation to this research study in chapter six.

**Table 5 Six Phases of Thematic Analysis**

| | Phase | Description |
|---|---|---|
| 1 | Familiarizing yourself with your data: | Transcribing data, reading and re-reading, noting down initial ideas |
| 2 | Generating initial codes: | Coding interesting features of the data in a systemic fashion across the entire data set, collating data relevant to each code |
| 3 | Searching for themes: | Collating codes into potential themes, gathering data relevant to each potential theme |
| 4 | Reviewing themes: | Checking if the themes work in relation to the coded extracts and the entire data set. Generating a thematic map of the analysis |
| 5 | Defining and naming themes: | Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme |
| 6 | Producing the report: | The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating the analysis back to the research question and literature, producing a scholarly report of the analysis |

(Source: Braun and Clarke, 2006: 87)

## 5.8 Credibility of the Study

In quantitative research, a study's credibility is measured using validity and reliability. Validity is described as an assessment of the appropriateness of the chosen method to reflect accurately the concept that it is intended to measure (LoBiondo-Wood and Haber, 1994). Parahoo (1997: 38) gives a more succinct definition, saying: *"A method is valid when it measures what it sets out to measure*".

These definitions are concerned with measurement of some kind - a quantitative concept, thus the position is well defined. The validity of a study can be measured,

for example, by applying statistical analysis. The generalisability and replicability of a study (and therefore the quality of that study) are dependent on using a tried and tested instrument, which can be repeated with little, or no change in the results and which answers the question posed. The use of the word validity in qualitative research however is more open to debate. A number of researchers suggest that 'validity', is a quantitative concept that is better replaced by other words, phrases and methods. Cutcliffe and McKenna (1999) debate the issue, concluding that qualitative research needs to prove its worth as a science by showing that the findings can be believed, but that this needs to be done in a different way. Taking this a step further, Rolfe (2006) argues from the position of judging each study on its own merit, be it qualitative or quantitative.

In phenomenological research, being true to the research method is proposed as the best test of rigour (Rose *et al*, 1995). More traditional methods have also been advocated, mixing qualitative and quantitative research in method triangulation (Mays and Pope, 1995; Tobin and Begley, 2004). However, this can lead to ambiguity, according to Cutcliffe and McKenna, (1999), who state that this can make credibility even more difficult to establish. Ways that can be used to demonstrate the accuracy in presenting the participant's experience in phenomenological research are shown in table 6.

**Table 6. Establishing Credibility in Phenomenological research**

| Author | Method of Establishing Trustworthiness | Trustworthiness Established by |
|---|---|---|
| **Collaizzi (1978)** | Final (significant) statement given to participant to verify researcher's description | **Participant** |
| **Sandelowski (1986)** | Decision trail apparent to reader. Comparable conclusions can be drawn from presentation of data, perspective and situation | **Reader / Co-researcher** |
| **Mays and Pope (1995)** | Independent assessment of transcripts by another skilled researcher | **Co-researcher** |
| **Koch (1998)** | Descriptions of how conclusions reached with full transcript included for analysis by reader | **Reader** |
| **Willig (2001)** | Interactive interviews with participant, giving opportunity for clarification of meanings | **Participant / Colleagues / Other Researchers** |
| **Smith and Osborn (2003)** | Use of text to support emergent themes and analysis | **Reader** |

As can be seen in table 6, Reader, Co-researcher or Participant may all play a part in establishing the validity or trustworthiness of the research. In this study, credibility was established by using several of the above methods. An independent review of two antenatal and two postnatal transcripts was made by another skilled researcher, and by the supervisory team. Emergent themes from the interview transcripts and analysis and interpretation of data that followed were also presented to the same group for discussion and further analysis. All comments given were used to inform and clarify the final analysis.

All themes and analyses were supported by quotations taken from the transcripts, and a coded transcript is presented in appendix 6, to enable the reader to see the process of developing themes that arose.

## 5.9 Limitations to the Study

As with any research method, limitations can be found. Limitations related to the use and understanding of language are discussed by Willig (2001). These limitations can be seen to apply to phenomenological research. The first point is the assumption that the language used by the participant would be understood to have the same meaning by the researcher; the second relates to constraints faced when using one method of expression to describe another; and finally, the process of analysing, understanding and making sense of people's experiences moves away from comprehending the immediacy of the experience itself.

These limitations were given due consideration. Talking to a woman '*on her level'* is a skill that midwives develop very quickly in their professional life. Midwives have to be able to communicate with and care for women, and this means that a rapport is quickly established between them. Inherent in this is mutual understanding of the language of reproduction, of feelings and emotions (the '*fusion of horizons'* discussed in section 5.4.4). In addition to this, I had lived for almost 20 years in the area, so was familiar with vernacular and idiomatic language[11]. A reflective style, aided by exploratory questions during the interview would confirm meaning. I anticipated that I would be able to adequately describe the experiences of women,

[11] When first working in the unit I had puzzled a woman by asking if she had a comb, the local word being pronounced coom (as in room) – a subtle, though important difference in mutual understanding.

though acknowledged that in writing of a narrated experience, it is difficult, though not impossible to capture more subtle elements such as inflection of tone or body language. These can sometimes convey as much meaning as the spoken words. The use of field notes, or notations on the transcripts would help in this matter.

### 5.10 Interviewing as a Method of Data Collection

Using interviews as a research tool for obtaining data is frequently seen in qualitative research (Shaw, 2001), and particularly in phenomenological studies. It has been suggested that nurses often choose interviewing as a technique because it is a process commonly used as part of their clinical work, (Price, 2002). There are however, a number of interview methods. The type of interview chosen for the research should be determined by the data required and the accessibility of the interviewee (Streubert and Carpenter, 1999). In this study, the interview needed to have the flexibility to allow the woman to discuss aspects that were important to her, whilst having enough focus to enable the interviewer to gain insight into the questions posed by the aims of the study. To meet these two conditions, semi-structured interviews were chosen, with interviews to be carried out on an individual basis, as this gave the opportunity to explore expectations and experiences in depth with each woman. Face-to-face interviews would be used. An interview guide was written which could be taken to each interview, ensuring that all aspects were explored (shown in appendix 7).

Establishing a sense of trust between interviewer and researcher was likely to enable the gathering of rich data, (Moyle, 2002), and was therefore a desirable feature of the interviews. There were several views of how this could be achieved, for example, multiple interviews with the same person (Seidman, 1998); the researcher sharing something of themselves and their own experiences, (Boyd, 1993), although the things shared should be relevant to the situation, according to Jones (1997). Women are often curious about midwives' own experiences, and will ask questions and be genuinely interested in the response. This was an aspect the researcher was practised in, which was felt to be helpful. Other tips for interviewing included interactions such as nodding the head and making eye contact during the interview, as this made the participant feel valued, and that they were contributing something of interest (Sorrel and Redmond, 1994). The ability to promote a more friendly, conversational, rather than inquisitional approach during an interview may also be helpful, as

suggested by Phillips and Davies, (1995), though this is tempered by Burgess, (1984), who states that the conversation is purposive, rather than casual. The notion of trust between researcher and participant was especially relevant, as sensitive topics might arise from women's experiences of transfer. Establishing a rapport with participants was therefore seen as an important step in the collection of data.

### 5.10.1 Establishing a Rapport

Being an experienced midwife was an advantage informing a relationship with each participant. Midwives are skilled health professionals, used to listening and questioning (Holloway and Wheeler, 2002), and learn quickly about establishing a rapport with women – indeed, this is an essential part of midwifery training as it enables them to care for a woman during sensitive and often intimate circumstances. Midwife and woman must share a common language in order to be able to communicate effectively.

As the women would choose to take part in the study with the knowledge that they would be interviewed about their experiences (see Woman's letter of explanation, appendix 8), it was felt that they would be happy to talk. As Atkinson and Silverman (1997) suggest, an interview is an accepted form of research today.

## 5.11. Ethical Approval for the Study

Before women could be approached about taking part in the study, ethical approval was needed from the University Research Ethics Committee, the NHS Trust Research and Development Committee and the South East Wales Local Research Ethics Committee (SEWLREC). Application to the various groups was supported by the required documentation (appendix 9), and patient consent forms devised, shown in appendix 10. Before submission for ethical approval could be made, potential problems which might arise as a result of the research were anticipated and consideration given to how they would be addressed.

Several risks were identified: women might feel an obligation to take part in the study if their named midwife promoted this, or if they had received care from the researcher in the past. This reflects the power relations arising when health care is provided. Carer and participant are rarely in a position of equal power, with the carer

being dominant. In this instance, participants would feel powerless to refuse to take part (Holloway and Wheeler, 2002), and so would not be able to exercise their right of informed choice. If birth did not go as planned, women might feel unhappy or traumatised and need specialist help to deal with these aspects. As the researcher was employed in the department where the research was to take place, this might lead to a conflict of interest should the woman have a complaint about the care she received.

For this study the three principles described in the Belmont Report (DoHEW, 1979) were used to reflect on areas that needed to be considered: Respect for Persons, Beneficence and Justice. To comply with respect for persons, information sheets were produced to outline the title and purpose of the study (appendix 8). This raised an important point, which Silverman (2005) describes as the 'dilemma' of wanting to give information to the subjects without being too specific about the exact research question. Leap (2000) discusses the subliminal messages that midwives give to women by the way they speak and act. She emphasises that by believing in a woman's ability to birth her baby successfully without intervention, the midwife helps the woman to gain self-confidence in her ability – a self-fulfilling prophesy. When discussing the study with women it was therefore important not to imply that there was a likelihood of transfer, so as not to introduce elements of self-doubt. This was avoided by discussing postnatal interviews with reference to finding out women's experiences of labour and birth. Women were asked during the antenatal interview if they would be willing to be interviewed again postnatally, but informed that only a few postnatal interviews would be carried out.

The requirement for informed consent was met by sending the information leaflet out to potential participants two to four weeks in advance of contact by the researcher, to allow enough time to decide if they wished to participate. Anonymity was maintained throughout by allocating participants a pseudonym, to be used in all written data with the real identity of the woman known only to the researcher. Data were stored securely in accordance with data protection guidelines, which restricted access only to the researcher, and would ensure their disposal in compliance with University regulations on completion of the project.

Although the study was not anticipated to be harmful to women, beneficence was nevertheless a consideration. Should a woman find recounting her experiences to be traumatic, then referral to an appropriate counsellor or her General Practitioner (GP) would be offered. The woman's GP was notified (appendix 11) of her participation in the study with her consent, in preparation for this possibility.

Midwives were inconvenienced as little as possible, as it was not desirable to burden them with more work. The study outline was discussed with the midwives, and an information letter prepared (appendix 12). To maintain the woman's confidentiality, I would not discuss individual interviews with the midwives in the birth centre.

As I did not work as part of the normal workforce within the birth centre, it was unlikely that I would be involved in any day-to-day care of women. However, any women known to me or for whom I had previously provided care for would be excluded from the study. This would be able to be confirmed from the woman's case-notes.

The need to observe justice was met by posting information letters to women, although midwives could discuss the study with the women if asked. This gave an element of distance for the women enabling them to make a free choice about participation.

As the study was conducted in an area where the researcher had management responsibility there was a potential conflict of interest if women wanted to be critical of their care or carer. The women were not informed that I was the manager of the midwives, only that I was a research midwife. If anything was disclosed that I felt warranted further investigation, then the Trust had robust policies in place that would deal with these. Any complaints could be directed to the Trust complaints procedure, and any untoward incidents would have already been investigated through appropriate channels. (No complaints were made.)

Ethical approval was gained from all necessary areas before the study commenced.

## 5.12 Researcher Reflexivity

The nature of Gadamerian phenomenology requires that the researcher has some information or knowledge about the subject being studied. However, empathetic analysis is only part of this method of enquiry. To ensure that the researcher is open to new ideas the researcher must acknowledge what they already know and have experience of, in order to set this knowledge aside, to *'pre-suppose nothing'* (Ashworth, 1996: 1).

I am a woman, a midwife, and also a mother, therefore have knowledge in the area of childbirth from several different perspectives: as a woman, I might not have personal experience of childbirth, but this belongs to my gender. As a mother and midwife I have experienced this phenomenon from two different viewpoints.

On a personal level, my first baby was born in another hospital from the one planned, giving me first hand knowledge of what an unplanned transfer meant to me: different staff, the entity of an unfamiliar unit, a different birth from the one anticipated. As a midwife, I could rationalise all these aspects as part of motherhood, but as a woman, it was disappointing that my daughter had her place of birth registered in a different town – I too had a strong sense of the community in which I lived. Having acknowledged the strength of my feeling on this particular aspect, however, meant that I could set it aside, and ensure that it did not impose on the study (in actuality, this was not an issue for any of the women interviewed).

During the interview, I intended to explore the woman's background, so that I might understand her views from her perspective, rather than my own. I planned to use a reflective style to further question, or show I understood as the interview progressed, to ensure that we had reached our personal horizon of mutual understanding, as suggested by Gadamer (1976). In this way, I felt that the limitations emphasised by Willig, (2001), and the influences of researcher bias had been fully addressed.
An additional aspect for reflexivity was to consider my role as a midwife manager, when carrying out midwifery research. It was not known at the commencement of the study whether the initial complaints about care that acted as the catalyst for research occurred frequently, or were particular to those individual women. From a midwife manager's perspective, it was initially hoped that this research study would

uncover the reasons behind, and offer solutions to those aspects of discontent with the service. This was later felt to be a naïve aspiration, and as the study progressed it became apparent that this would not be feasible. The study would of necessity be small-scale, and therefore would be able to contribute towards what was known of women's experiences of care, but not to give definitive advice about changing aspects of care.

Having been a midwife for a number of years, I had observed and heard about many different experiences of care. Even so, some of the experiences related by the women in this study still had the power to shock. The emotion with which the women related their stories was intense, and though I believed I was able to remain impassive during the interviews, their stories provoked reactions such as dismay (that these situations could arise), outrage (on their behalf) and defensiveness (that care had fallen short of what I would have expected). After each interview, whilst completing my field notes, I made a conscious effort to identify and record my own feelings and impressions, both positive and negative, so that these could be acknowledged prior to carrying out data analysis (an example of a field note is shown in appendix 13). Hearing about undesirable aspects of care was a difficult part of the interview for me, and the reaction as midwife manager to want to investigate these episodes further had to be resisted. In these instances, I was given information as midwife researcher, not as midwife manager dealing with a complaint (in fact the women were unaware that I was a manager). I had to respect the women's confidences, and trust that they would follow other channels available to them, if they wished to complain about their care.

### 5.13 Summary

The methods considered in the planning of this study led to thematic analysis, underpinned by Gadamerian phenomenology being the method of choice. This addressed the needs of the study, fitted with the theoretical framework, and met my needs as researcher. The sample of women would be chosen from those who anticipated giving birth in the birth centre, and semi-structured interviews would be the means for data collection. Ethical approval was sought and agreed, and the study commenced. The next chapter describes this process, detailing how the study was undertaken.

# Chapter Six: The Research Process

This chapter describes the research processes followed in carrying out the research. These involved selecting a suitable group of women to be recruited into the study, and arranging interviews at the appropriate time, with some women, (those who had been transferred), being interviewed twice. Data were taped and transcribed, and analysed with the aid of a computer software programme, following the principles of Gadamerian Phenomenology. Thematic analysis was used to identify themes arising from the data. Themes were grouped and reduced, until the final themes were apparent.

## 6.1 Selection and Recruitment

In this study, a 'purposive' sample was used, with participants chosen on the basis that they have or will experience the topic under review (Lincoln and Guba, 1985; Patton, 1990). Often, as was intended here, the researcher includes subjects from different demographic groups, to try and obtain a rich mix of information from the participants.

The number of people in a sample varies according to the type of research being undertaken, for example, a quantitative study will need to include enough people from the population to reflect the views of all the target group (a representative sample). In qualitative research, sample sizes tend to be smaller, as the subject under review is particular to that culture, situation and time frame. In other words, the results will not be held as being representative of the population as a whole. The sample would be chosen from those booked to give birth in the birth centre depending on their expected date of delivery (EDD), would include women from different areas, and cared for by different midwives. This was to try and gain an overall impression of care in the birth centre for women from different areas in the valley, rather than care by an individual midwife, or women from a specific area. The purposive sample would comprise women having midwife-led care who planned to give birth in the birth centre and who had reached the final few weeks of pregnancy.

By using the known transfer rates of the birth centre[12] it was calculated, given the time constraints for the fieldwork and the possibility of women needing transfer of care at the salient point, that an antenatal sample group of twenty to twenty-five women would contain approximately four to ten women who had undergone transfer. The final sample of women contained two groups, one group interviewed in the last few weeks of pregnancy – the antenatal sample (20 women), and a smaller second group of women from the antenatal sample who had care transferred, who were interviewed again after the birth – the postnatal sample (five women).

Practical considerations about the number of women to be recruited on a monthly basis were also made, as time was the main constraint. The time span allocated for the interview phase was a maximum of twelve months, with two to three interviews being the target for each month. The number of women interviewed in the latter part of pregnancy was of necessity greater than those interviewed in the postnatal period, as only a few women had care transferred before birth. Antenatal interviews continued until five postnatal women were interviewed.

Women were recruited into the study after receiving an explanatory letter through the post (see appendix 8) at approximately 34 -36 weeks of pregnancy. This allowed the woman to seek further information if she wished, and allowed sufficient time for consideration prior to making an informed choice to participate in the study. A telephone call was then made to the woman to see if she wished to take part in the study, accompanied by a brief explanation about the interview. An appointment was arranged for interview at a time and place convenient to the woman, which was usually in her home. At the antenatal interview, women were asked if they were willing to be interviewed postnatally. For the postnatal interview, arrangements were made by telephone, again, at a convenient time and place for the woman.

[12] Consistently, the birth centre transfers approximately 11% of women during labour, and of the 30% of antenatal transfers, approximately a third are transferred for induction of labour, the most common reason for late pregnancy transfer, see appendix 2.

## 6.2 Collection of Data

Data were collected from semi-structured interviews with women, which were taped and later transcribed. Field notes were made following each interview, to record personal thoughts and reflections, and provide background information that might be of value during data analysis, for example, whether it was easy to establish a rapport with the woman, or whether other people were present during the interview (appendix 13). In both ante and postnatal interviews, the purpose of the interview was discussed with each participant at the beginning of the session. Verbal agreement was sought on both occasions about the use of the tape recorder, with an explanation given about confidentiality and data protection.

An interview guide for antenatal interviews was devised with the aid of the research supervision team, as an *aide memoir* to enable exploration of certain aspects with all the participants (see appendix 7). This ensured that all the aims of the study were addressed by asking the appropriate questions. The interviews did not follow a set pattern as each interview was led by the participant's response. This allowed the flexibility to explore any experiences unique to the individual more fully, whilst maintaining the ability to establish common ground in the participants' experiences (Holloway and Wheeler, 2002).

Postnatal interviews did not require an interview guide, as their purpose was to explore women's experiences of labour and transfer. The woman had already discussed her expectations for labour and birth, so the second interview was a natural progression from this, finding out the conclusion to the story by asking for a full description of how she had experienced labour. A summary sheet of each woman's expectations for labour was available, however, if there was a need to prompt women about how they had expected labour to be (appendix 14).

To set the scene and put the woman at ease, the antenatal interview began with general questions, which gave the opportunity for the woman to get used to talking with the tape recorder running, and after a few seconds, the women did not appear to feel self conscious about this. The woman was first asked to tell a little about herself. As well as providing useful background information, this gave cues on how to pitch the interview – what type of vocabulary to use; whether the woman felt

comfortable talking freely, or would need a few prompts for example. This was important when interviewing women from different educational and cultural backgrounds, as it offered the interviewer the opportunity to change the wording of a question without altering the meaning – in other words, asking the women questions and encouraging discussion at a level, and in vocabulary that they understood (Barriball and While, 1994). Using 'small talk' gave a lead in to more sensitive questions later on in the interview – what Price (2002) described as 'laddered questions', enabling a deeper exploration as the interview progressed.

During postnatal interviews, the rapport was re-established by recalling some of the small-talk from the antenatal interview, which quickly seemed to recapture our previous relationship. Questions such as "*tell me about …*", or "*what did you feel when…?*" allowed the participant to respond in their own way. Body language was open, and non-verbal responses such as nodding and facial expressions promoted the feeling of engagement with the participants.

Open-ended questions were favoured to allow the participant to formulate her own response. From this, pertinent questions were asked and prompts given, whilst allowing the women to express themselves fully and in their own words. Prompts and checks such as "*by that, do you mean…?*" were used to clarify any ambiguity, and the use of a reflective technique during the interview confirmed that meaning been properly understood by the researcher. As discussed by Parahoo (1997) the interview guide was helpful for giving structure to the interview process, but the amount and type of discussion depended upon the interaction that was present between the researcher and respondent, and so differed from person to person.

A few problems were experienced during the recruitment process, associated with the timing of the interviews, and the response of women when asked to participate in the study. The timing of the interview in the antenatal period was difficult to judge, with one woman going into labour and being transferred a few hours prior to the scheduled interview. Postnatal interviews, although intended to be carried out within a few days of birth proved impractical to arrange, so were held when it was more convenient for the woman, usually during the third week after birth, but in one instance at five weeks postnatally.

The timing of postnatal interviews was a consideration, as with the passage of time, some women may change their interpretation of birth experiences, in some ways trying to sanitise the event. Several authors have observed this phenomenon. Shearer (1983) discusses the difficulties in measuring satisfaction with perinatal care, proposing the women develop a loyalty to their birth experience, regardless of what it is. Smith, (1995), refers to how women may change their account of the process of becoming a mother over time, which he concludes is due to a number of reasons: the need of a new mother to maintain a view of herself as the same person, whilst establishing a new order in her life by dealing with the changes a new baby inevitably brings. These views, however, are balanced by other studies, which have demonstrated that women have good long-term recollections of birth, for example Murphy *et al,* 2003. I concluded that holding the interview in the first few weeks after birth would not unduly affect women's recall of their experiences.

Women in certain geographical locations declined to participate in the study. These were the most socially deprived areas in Cwm Fechan. Although these were not the only women to decline, it would have been interesting to find out why women did not want to take part in this study. There was no attempt to pressurise women to take part in the study, although some women may have felt uneasy about saying no as they asked a third party to decline on their behalf.

### 6.3 Analysis and Interpretation of the Data

Using thematic analysis requires the researcher to engage with the interview texts, and this process began with all interviews being transcribed from the tapes by the researcher. This allowed the iterative process to begin by becoming familiar with each text prior to beginning the interpretative phase. Tapes were transcribed as soon as possible following interview which enabled a constant review and reflection on the interview technique. A summary sheet was then completed for each transcript showing the main aspects of the interview. This was used during the postnatal interview to explore issues to which women had attached importance (appendix 14).

After listening to the tape and transcribing the interview, each transcript was read through several times before the coding work began. Although Gadamerian phenomenology does not require a setting aside of one's beliefs in the same way that

other forms of phenomenology do, it was essential to read the texts with an open mind, to allow the woman's experiences to speak for themselves before beginning the process of coding – this ensured that each experience was considered on its own merit, and allowed the themes to be developed from the text. An example of a typed interview transcript is shown in appendix 15.

Thematic analysis was carried out, using a computerised programme (QSR NVivo™) to aid the derivation of themes from the data. Although this programme is complex, in this instance it was used in a very basic way to assign preliminary coding to data[13]. The typewritten transcripts were imported into the software programme and displayed on the screen. Points of interest in the first interview transcript were coded as *'free nodes'* in the NVivo programme. Subsequent transcripts were checked using these points, with further free nodes being created where new topics arose. Transcripts were checked and rechecked to ensure that all possible coding had been carried out. When all transcripts had been subject to this initial phase of coding, free nodes were amalgamated, developed and renamed, these being the introductory themes. An example of a coded transcript is shown in appendix 6. The emergent themes reflected those that had shared meaning for participants. Similar themes were clustered together under '*tree nodes'* in NVivo, giving 17 collective themes.

The programme could have been used further, to develop the final themes had I wished, but at that stage I felt it vital to return to the original transcripts. This allowed me to become immersed in the data once more, and ensured that the themes were grounded in the words and meanings of the participants. At this stage, developing the final themes was carried out, which were used to explore how experiences could be described in words that would convey and demonstrate their meaning. The reduction of themes is shown in appendix 16.

External validation was sought using an experienced independent researcher and the supervision team, who reviewed the themes with the supporting data. Agreement was reached on the collective themes that were then developed into final themes.

[13] The programme was chosen as support and training in its use was available from the university, as was a licensed copy of the software.

The discussion formed a vital part of the interpretative process, and also ensured that attention was given to completing the hermeneutic circle, with meanings from individual texts being explored and clarified in relation to other texts. The discussion and ideas that resulted were incorporated into the final themes.

These themes are now presented as the findings from the study, illustrated and discussed in the next chapter.

**Part Two – Findings of the Study**

# Chapter 7: Findings and Discussion

Chapter seven presents the findings from the study and offers discussion in relation to these. The limitations of the study are discussed. An overview of the participants is portrayed, accompanied by their demographic information. The final themes arising from the analysis are presented individually, supported by verbatim quotations from the participants. Each theme is discussed in relation to reviewed literature. Finally, the meaning of birth is discussed in relation to social constructionism.

The aims of the research were to look at what women wanted and expected from their maternity care, and what they actually experienced. To establish this, antenatal interviews focused on why women wanted to have care in the birth centre, their experiences of antenatal care, and their expectations of labour. Postnatal interviews elicited women's experiences of labour and birth when care was transferred, exploring their individual experiences.

## 7.1 Limitations of the Study

The study had a number of design and methodological limitations which were recognised either at the start of the study, or as recruitment took place:
It was carried out in one area of South Wales, and explored the experiences of a group of women who were cared for in a specific birth centre and its associated DGH. Other birth centres and DGHs may have had different ways of working, and offered different facilities, not comparable to those described in this study, meaning that women did not experience care in the same way, and may have chosen their care for different reasons to women in this study.

The women who participated in the study could not be considered to be representative of a cross section of women who either lived in the valley, or chose the birth centre for their care. This was because a purposive sample was used, and was limited to the number of women who agreed to participate, with women from areas of social and economic deprivation noticeably declining to take part in the study. There were no women from ethnic minorities in the study.

This, combined with the qualitative nature of the study meant that the findings were not generalisable, but represented the experiences of that group of women at that particular time.

Other limitations to the study design became apparent as the study moved to the interview stage. Several women discussed experiences postnatally, which would have merited a more in-depth exploration. These were not always returned to during the course of the interview, although a more experienced interviewer may have been able to do so, for example, the issue of the doctor's gender could have been explored during the interview with Penny (see section 7.11). An opportunity for a second interview with the woman would have provided the means to investigate these issues further.

## 7.2 Participants in the Study

Forty-eight women were approached to take part in the study, and of these, 20 agreed to be interviewed in the antenatal period. Nineteen interviews were carried out antenatally, the other woman going into labour on the arranged day of interview. During the antenatal interview, all the women agreed to take part in a postnatal interview, and of the 19 women, eight had care transferred, so would have been suitable. Four of the women later declined to be interviewed postnatally. The woman who went into labour on the day of interview agreed to be interviewed postnatally, where she also discussed antenatal aspects. This gave a total of five women who participated in a postnatal interview.

## 7.3 Demographic Information of Participants

The demographic information made an important contribution as it helped to place women in their background environment, therefore gaining an understanding of the cultural and social influences that might affect them as individuals and as part of their local community. This provided an important safeguard against stereotyping women. For example, Hunt, (2004), discusses how some midwives assume that all women from poor backgrounds are deliberately neglectful of their health and that of their children, a stereotypical image rather than a truthful one, assuming that all women living in the same environs are the same. Although her emphasis is on

poverty, the message is the same: it is necessary to look further than an address or postcode to find out about the individual.

There was, nevertheless, one common factor for all the women in this study: they had all chosen to have care in the birth centre. In chapter four the historical context of childbirth for women within Cwm Fechan was described, together with the prevailing social culture of the valley, which influenced how women saw themselves. Women who had recently moved into the area, however, might have different influences that shaped their views on maternity care.

The women who participated in the study were from areas throughout the valley, living in various types of housing, although no women took part who lived in the poorest, local authority estates. Most of the women lived in the villages where they had grown up as children, although four women had recently moved into the area (Alison, Ellen, Fiona and Sarah). Women's ages ranged from 17 to 34 years. The three youngest women classed themselves as unemployed at the time of the interviews, and four others were full time mothers. The remaining women had worked on a full or part-time basis prior to taking maternity leave, and planned to return to work after the birth of the baby. There were eleven women having their first baby and nine women in a subsequent pregnancy. All of the women were either married or in stable relationships, though not necessarily co-habiting with partners, as some women lived with parents or alone.

Table 7 shows a summary of the demographic information gathered from the women interviewed in the study, together with the outcome of the birth, where it took place, and the reason for transfer if applicable. Postnatal interviews with women are highlighted.

Pseudonyms are used for all participants and their families to protect their anonymity.

**Table 7. Demographic information of participants**

| Name | Age | Occupation | Parity /previous place(s) of birth | Type of Housing | Marital status / Living with | Type / place of birth ☐ Birth Centre ■ DGH | Reason and Time of Transfer |
|---|---|---|---|---|---|---|---|
| Alison | 30 | Retail manager | 0 | New detached | Married / husband | Emergency CS | In labour – slow progress * |
| Brenda | 17 | Unemployed | 0 | Terraced | Single / grandmother | Normal | |
| Carol | 25 | Travel Agent | 0 | Terraced | Single / partner | Normal | Antenatal – induction of labour |
| Diane | 19 | Unemployed | 0 | Terraced | Single / mother | Normal | |
| Ellen | 29 | Civil Servant | 0 | New detached | Single / partner | Forceps | In labour – raised blood pressure * |
| Fiona | 34 | Civil Servant | 2 DGH | New detached | Married / husband | Normal | |
| Gail | 29 | Teacher | 0 | Terraced | Single / partner | Normal | |
| Hannah | 29 | Retail clerk | 1 DGH | Local authority flat | Single / daughter | Emergency CS | Antenatal – APH |
| Isobel | 31 | Full-time mother | 1 Birth Centre | Local authority house | Married / husband | Normal | |
| Janice | 32 | Nurse | 2 Birth Centre | Semi-detached | Married / husband | Normal | |

**Table 7. continued.**

| Name | Age | Occupation | Parity /previous place(s) of birth | Type of Housing | Marital status / Living with | Type / place of birth ☐ Birth Centre ■ DGH | Reason and Time of Transfer |
|---|---|---|---|---|---|---|---|
| Karen | 27 | Full-time mother | 1 Birth Centre | Terraced | Married / husband | Normal | Antenatal – induction of labour |
| Lynn | 33 | Teacher | 1 DGH | New detached | Married / husband | Ventouse | Antenatal – induction of labour * |
| Maria | 17 | Unemployed | 0 | Terraced | Single / parents | Normal | In Labour – wanted epidural |
| Natalie | 31 | Full-time mother | 1 Birth Centre | Terraced | Married / husband | Normal | |
| Odette | 23 | Hairdresser | 0 | Terraced | Single / parents | Normal | |
| Penny | 22 | Secretary | 0 | Local authority flat | Single / partner | Normal | In labour – slow progress * |
| Rachel | 25 | Teacher | 0 | Detached | Single / parents | Normal | |
| Sarah | 28 | Retail Manager | 1 DGH | New detached | Married / husband | Normal | Antenatal – choice * |
| Tracy | 23 | Full-time mother | 1 Birth Centre | Terraced | Married / husband | Normal | |
| Val | 21 | Bank clerk | 0 | Terraced | Single / partner | Normal | |

* Women who were interviewed postnatally

## 7.4 Interviews

Interviews held in the antenatal period were mostly conducted in the women's homes, although a few were carried out when they visited the birth centre for an antenatal check. All women agreed to the interviews being audio-taped, and they typically lasted for 20 to 30 minutes. Three particular areas were explored during the antenatal interview: why women chose the birth centre for their care, what they expected and experienced from this care, and what they anticipated for labour and birth. All the postnatal interviews were held in the woman's own home, with the women being noticeably keen to show off and discuss their new baby. These interviews were of longer duration, lasting between 30 to 60 minutes. The aim of this interview was to establish women's experiences during labour and birth, and included two women (Lynn and Sarah) who had care transferred in the late antenatal period, as well as those transferred during labour (Alison, Ellen and Penny).

## 7.5 Themes

Thirty-eight introductory themes arose from the interview data, which were able to be reduced to 17 collective themes. These were separated into ante and postnatal interview sections. Several of the themes occurred in both sections so a further reduction was possible. This gave seven final themes. Theme one, the birth environment has two sub-sections relating to the physical environment and the midwifery model of care, whilst theme six, women's birth stories, includes meeting the challenge of labour, and their experiences of transfer. Findings are presented in relation to each of the final themes. Appendix 16 shows how the themes were reduced, and given a final grouping.

A number of themes related to subjects explored in the preliminary literature review (chapter 2), whilst others emerged during analysis of data. New themes are discussed in relation to extant literature in the appropriate section, following presentation of the findings. Table 8 shows the final themes that resulted from both ante and postnatal interviews. A brief description of each theme is provided, and the way in which the aims of the study are met by each theme is demonstrated. Pertinent literature is identified, with subjects not arising in the preliminary literature review being shown in italics.

**Table 8. Final Themes**

| **Theme One: The Birth Environment** | | |
|---|---|---|
| **Description:**<br>The environment and facilities within the birth centre and DGH.<br>Care which values women as individuals and as people. | **Aims Met:**<br>Why women chose the birth centre<br>Experiences | **Literature Review:**<br>The Birth Environment<br><br>Woman-centred Care |
| **Theme Two: Knowledge** | | |
| **Description:**<br>How women gained knowledge, what it related to, and the effects it had on women's experiences. | **Aims Met:**<br>Expectations | **Literature Review:**<br>Knowledge<br>Knowledge and Labour |
| **Theme Three: Anticipating Labour** | | |
| **Description:**<br>Women's thoughts on labour, pain and developing coping strategies. | **Aims Met:**<br>Expectations | **Literature Review:**<br>Expectations and Experiences of Labour |
| **Theme Four: Making Plans** | | |
| **Description:**<br>Ambivalent feelings towards labour and birth, "what if" scenarios and birth plans.<br>Viewing the effects of transfer, and its influences for future pregnancy. | **Aims Met:**<br>Expectations<br>Experiences | **Literature Review:**<br>Expectations and Experiences of Labour<br>Transfer of Care |
| **Theme Five: Women's Birth Stories** | | |
| **Description:**<br>Women discuss their birth stories during the postnatal interview. | **Aims Met:**<br>Experiences | **Literature Review:**<br>Knowledge and labour<br>Experience of labour and birth |
| **Theme Six: Experiences of Care Following Transfer** | | |
| **Description:**<br>Women's experiences of a different approach to care following transfer. | **Aims Met:**<br>Experiences | **Literature Review:**<br>*Experiences of Care Following Transfer* |
| **Theme Seven: Birth as a Family Event** | | |
| **Description:**<br>The importance of family for support, and integrating the new baby into the existing family unit. | **Aims Met:**<br>Why women chose the birth centre<br>Expectations<br>Experiences | **Literature Review:**<br>*Birth as a Family Event* |

## 7.6 Theme One - The Birth Environment

There were two sub-sections to this theme. The first was associated with the physical environment, which was found in the birth centre, the second associated with the philosophy of care that was provided.

### 7.6.1 The Physical Environment

The birth environment that existed in the birth centre appealed to the women in this study. They liked the idea that the birth centre was informal, small and friendly and that they could have their family and friends around them, perpetuating the homely atmosphere. They did not want to feel that care was going to be regimented or rushed, and this was especially important when looking forward to the time when they would be in labour. Alison and Fiona, both recently moved into Cwm Fechan, had visited the birth centre prior to making their choice, and their impressions contributed to their decision.

*"I just think the atmosphere is nice and casual....yeah, I think I'm just quite a laid back person and I just like the idea really of going to the centre."*
*ALISON*

*" I went down to have a look before I made my decision, and they showed me around and I just thought 'oh yes, it's really nice'."* *FIONA*

Other women had experienced the birth centre previously either themselves, or visiting friends and relatives who had gone there.

*"The main one ... my sister had her first child in the birth centre, and when we went up to visit… well, it was just lovely up there. It just seems to be, I don't know, so relaxed."* *CAROL*

*"My friend had her baby there (birth centre) and she said her experience was really good - everyone was nice and friendly, it was laid back, and not so much like a hospital, informal, the visiting hours, and my partner being able to stay - it just seemed less regimented."* *ELLEN*

Ellen was not the only woman who differentiated between 'hospital' and birth centre.

*"I'm gonna be prepared for that, I might have to go to hospital."*
*ALISON*

In this context, the DGH obstetric unit was synonymous with the word hospital – a place of sickness rather than health. The women in the study were all healthy, having a normal pregnancy, and perceived the birth centre as being different, separate, regardless of its being sited within a community hospital[14].

Women wanted to feel at ease with their surroundings, and thought that the birth centre would provide this. They wanted to experience the sense of peace that they felt the birth centre would give. Hospitals were felt to be far more formal and restrictive, and therefore disliked.

*"Yes, its peaceful there (birth centre) - nice and homely and friendly - I hate hospitals."* *BRENDA*

*"Over there (talking about her friend giving birth in the DGH), it was restricted (visiting) two to a bed, so she couldn't see any people."* *PENNY*

The facilities on offer were also attractive to women, particularly the birth pool that had recently been installed.

*"My preference was to have a water birth, so I kind of thought, oh I'll have to travel, maybe to (names an affluent Market Town about 50 miles away) or somewhere like that y'know, private, then we heard there's a pool in the Birth Centre, so we couldn't believe it, so really that's been the main reason."* *ALISON*

*"It's really nice, and since they've had the birthing pool, I quite like that idea."* *VAL*

For some women, a local unit gave advantages; accessibility to deal with problems, visiting and other children were all cited as reasons.

*"And it's so convenient, you can just pop down if there's a problem if you are worried about anything."* *FIONA*

*"I think with this one, its more to do with my son, 'cos he's going to be here, and the proximity - its close by, so he'll be able to come back and forth, its easier, much easier, and now I've seen the unit, its my choice."* *LYNN*

[14] The birth centre is on the same site as a local community hospital, but in a different building with its own entrance.

For Lynn, in her second pregnancy, introducing the baby into their family unit was part of the attraction of having easier visiting arrangements – her son would be able to spend time in the unit, and not feel that the new baby was excluding him from spending time with his mother. It was also the first time that some women would be separated from other children, and possibly the first time that husbands or partners were going to be in charge of the family arrangements. The proximity of the unit and the open visiting policy were reassuring as they would be easily accessible to sort out any problems that might arise.

Having such a local facility was seen as quite an asset when considering children, but for a first-timer like Gail, social influences were also at work:

*"I think it was a decision we came to, I mean, I live in the Valley, and I think once we got pregnant, it felt the right thing to do."* *GAIL*

Gail was keen to support a local facility, especially when it was advantageous to her and her family, for easy visiting. Other women also cited this reason as being a reason for choosing the birth centre:

*"My mother works on one of the wards there (in the community hospital), and I knew she wouldn't have to take time off work to see me, - she's my birth partner, and so is my partner I think that's why I booked in there."* *ODETTE*

*"No, my mother said it'll be better for me to go to the birth centre, its more local and everything."* *DIANE*

Family members, particularly mothers, seemed to be a positive an influence. (However, a different perspective is described on p 169).

As well as being easier for families and children to visit, there was another underlying factor for several women: birth was a principal social event, which needed to be shared and celebrated with friends and family. Isobel, talking about her previous birth, explained why this was an important aspect of making her choice:

*"My family can come at any time. In (DGH) they've got to come at visiting times, its two to a bed, ah, you want your family don't you, I do - I'm close to my family so that's important for my family, you know, 'cos I wanted my mother in with me, my sister was supposed to come in with me as well, and my partner, so that was ok there." (in the birth centre)* *ISOBEL*

### 7.6.2 Experiences of Care in the Birth Centre

The care provided by midwives in the birth centre was consistent with a midwifery model of care. This philosophy of care focuses on the needs of the woman, and ensures care that is grounded in the philosophy of being woman centred. This aspect drew women to the birth centre. Women recognised that the midwife would play an important role in their lives for a short time, and they wanted to be able to develop a relationship with 'their midwife'.[15] Additionally, continuity of care was a feature of the women's experiences. Sarah had developed a good relationship with her midwife in her previous pregnancy, whilst Fiona had not been so lucky:

*"The most prominent person in my care last time was my midwife."*
*SARAH*

*"And you do get better… y'know, more of a one to one, well that's what I'm hoping for, anyway, rather than sort of ... because when I had my second child I was more or less left to it and I did feel, well, I could have just been in a field, so I thought well, y'know I might have more of a one to one so that's what I'm hoping for."*
*FIONA*

Fiona had felt abandoned by the midwives during labour with her second child, and although she had experienced labour before, she had wanted and expected to have a midwife with her at this time. This aspect of one-to-one care was vitally important to Fiona.

When making their initial choice for birth centre care, women relied on the evidence of friends or relatives who had used the birth centre, or went along to visit the unit for themselves, to see what sort of impression they gained. Although physical aspects such as the birth pool, or being able to move about in labour contributed to their choice, the overwhelming response was tied to the atmosphere which they perceived, and the attitudes of the midwives who showed them around. From this, the women derived the impression that they were important, that care would be tailored to their needs, and that they would be given the support they needed to enable them to make choices about their care.

[15] This was enabled by the way in which the birth centre midwives work, each having an individual caseload of pregnant women, for whom they provide the majority of care (see p 118 for further discussion).

These views were reinforced by women's experiences during the antenatal period. For example, women found that they were always made welcome and treated with kindness when they visited the unit, regardless of which midwife they saw:

> *"I've come across one or two others (midwives) when I've gone up there, and if you're really worried about something, and they've all been really… everybody's treated me, y'know… "Oh, come and sit down" they've been really nice and helpful."* *HANNAH*

Being able to make their own decisions during labour was an important issue for women when considering where to have their baby, as Odette stated: *"The way I look at it, I want to be in control."*

Brenda expressed a similar opinion: *"You don't have to do anything you don't want to do."*

The implication here was that women felt confident that they would be allowed to be in control during labour, supported and encouraged to do what they wanted, letting nature take its course. Penny articulated the perceived contrast to the obstetric unit, where she felt women adopted a passive role and accepted medical intervention:

> *"The reason I want to come here is that it's more laid back and in a lot of books I've read, it says the trouble with hospital birth (obstetric care) is they tend to rush things, and its more… formal really."* *PENNY*

The informality of the birth centre, and the support from midwives was seen to be a feature of the care the women received antenatally. The care given by the midwives was both personal and focused on each woman as an individual. This was commented upon by the women, who felt that the midwives were friendly and helpful. Fears and worries were never trivialised by the midwives, but dealt with sensitively. Gail joked about telephoning the birth centre all the time:

> *"I had contact with chicken pox as well, so I rang about that, so they explained it was ok if I'd had it myself. They have been brilliant every time I've rung up."* *GAIL*

Sarah also admitted that she rang often, sometimes with issues that just needed her to use her common sense, though the midwives never suggested this:

*"There's not a single time I've felt stupid or that any of them are inaccessible, or anyone I've spoken to, even if I've not met them they've been very approachable."*
*SARAH*

Sarah raised the point, echoed by other women, that this attitude extended to all the midwives there, not just the named midwife, thus reflecting the underlying philosophy of the birth centre, shared by the midwives. The midwives were adept at making women feel as if they were known, even if they just happened to be the person answering a telephone enquiry. This gave the women the feeling of continuity of care that they wanted:

*"Yes, when you 'phone up they say 'Oh Gail or Hiya Gail'... its all first name terms and they always seem to know who you are instead of having to look you up which you feel nice about, like you're not on a big huge list, they all sort of know about you."*
*GAIL*

There were a few negative experiences associated with the emphasis on normality and informal approach of the midwives, described by Alison, who had read many pregnancy books, and who compared much of her care (good and bad) to that of pregnant friends, living in another area:

*"So, in a way I was thinking oh crikey, you know, what am I missing? And they are going 'ooh, you've got to be tested for diabetes and ooh this, that and the...' and in that way it kind of makes you worried that you're not being seen as often as you should."*
*ALISON*

Alison had a suggestion to make about her care, which she would have found helpful:

*"I do think that perhaps at the start of my care I should have been told perhaps, y'know, 'you won't be seen…' – because of the books as well see, ooh at 32 weeks you should be seeing them now every two weeks or whatever, that maybe we'd have been told...'cos my husband's been more hepped up about it than me y'know. But, umm, maybe if we'd been told oh, y'know, just expect to be seen maybe once a month to six weeks, y'know we'll see you, that, that had it been a bit more planned out like that…. Some points I was thinking 'ooh crikey, they've forgotten us' y'know."*
*ALISON*

Although Alison had felt that she had in some ways missed out on antenatal care (although she had not), she and other women liked the convenience of their appointments with the midwife. Appointments were made by mutual agreement at a time and place to suit. This might be in the woman's own home, the GP clinic or the birth centre, and midwives would see women at any time when they

were on duty. This was appreciated as the woman felt that she was the focus of that care – it was more than just checking on the progress of the pregnancy, she too was important, and did not need to be inconvenienced. There was an added advantage with this giving the opportunity for husbands and partners to be involved:

*" Yeah… I've been up there at nine o'clock on a Friday night if she was working, literally nine o'clock, so my boyfriend could come as well y'know." CAROL*

*"They either come to the house, you know with me working shifts, and (names midwife) is working its like, oh pop in on the way home type of thing, its so easy going and laid back." JANICE*

The midwife, providing caseload care became a constant figure during the pregnancy, getting to know the woman and her family well, and in some instances being seen as a kind of friend. This reinforced the feeling of being the focus of care:

*"Yeah, its like…more personal, I feel I can ask her things, its like… dealing with someone who knows you and knows all about you." HANNAH*

### 7.6.3 Discussion

It was demonstrated in the preliminary literature review that the fundamental aspects of the birth environment, a comfortable physical environment accompanied by an enabling and trusting relationship with caregivers affected women's perceptions of labour and birth (section 2.6). For women in this study, this theme was also very important. All women interviewed mentioned one or more features which influenced their reasons for choosing the birth centre for maternity care, and these were reflected in their experiences of that care. Different aspects appealed to different women but the physical environment and the philosophy of care provided by the birth centre was important to all the women in the study.

In the study carried out by Newburn and Singh (2006), a pleasant and homely environment, which was clean, comfortable and welcoming was found to be important to women, and this is reflected in the results of this study. The welcoming environment was particularly attractive, as were the single rooms, birth pool and open visiting arrangements. What women talked about most was

the atmosphere in the birth centre, which they felt to be calm and relaxed. This was seen as a great advantage, and one which meant that the birth centre was seen as a separate entity to that of a hospital, where things were seen to be much more formal and rushed. This concept was important to women from the beginning of pregnancy, as they felt that the birth centre facilitated their aspirations for normal labour and birth, without medical involvement.

In a study by Hundley *et al*, (2001), it was suggested that women would prefer a maternity unit which had routine intervention as an expected feature of intrapartum care, specifically, routine cardiotocography, and involvement of medical staff. This was in contrast to what was found in the birth centre, where these features were considered undesirable. Women booking care in the birth centre were made fully aware of the facilities that were and were not available, including the need to transfer to the DGH if complications arose in labour. The possibility of needing medical intervention was not considered by women until later on in pregnancy, when transfer was considered, although not in any detail (see section 7.9.3).

The type of care provided in the birth environment was a subject that featured prominently in this study. What is commonly known as a midwifery model of care developed from the original concept of woman-centred care, a central tenet of the *Changing Childbirth* report (DoH 1993). This report urged the provision of safe care which was *'Kinder, more welcoming and more supportive' (DoH, 1993, pII)*, based on the elements of '*Choice, Continuity and Control'.* The birth centre midwives adopted these as the main feature of their care.

Both obstetricians and midwives provide woman-centred care, however in a midwifery model of care, the emphasis is on normal labour and birth. This type of care represents a philosophical attitude by carers, who view birth as a normal physiological process, a factor that Pairman, (2006) cites as being the main difference between the midwifery model and the medical model of care. In the midwifery model, women are encouraged to make fully informed choices about their care, and are treated as partners in, rather than recipients of, care. This philosophy embraces an equalisation of power between professional and woman,

achieved through the sharing of knowledge, and valuing the woman as an individual who shares the responsibility for the health and well-being of both herself and her baby (Carolan and Hodnett, 2007). As this model represents a particular philosophy, it can, confusingly, include care by medical staff, just as a medical model of care (section 4.2) may be embraced by midwives. In this instance however, the midwifery model of care was provided by birth centre midwives, with the woman being the focal point of all aspects of maternity care, summed up by Hanson *et al* (2001: 18) as *"Maintaining the woman's role as star."*

The original information leaflet used from 1995 onwards states:

> *"Your midwife will meet you in early pregnancy and discuss with you your preferences for care and the birth of your baby."*

Although this was an inherent part of the midwifery model of care experienced by women, it merited being considered in its own right. The birth centre itself met the first objective of woman centred care by giving women an additional choice of where to give birth. Together with the midwifery model of care, '*continuity*' was a prominent feature of women's experiences. They particularly liked having care from an individual midwife, as this enabled them to develop meaningful relationships with midwives, who they felt knew about them, as the quotation from Hannah (p 123) demonstrated. Women who had experienced other forms of care preferred the concept of continuity from an individual midwife:

> *" Apart from one time when (names midwife) was on holiday, she's done all my care. That's different as last time I saw quite a few different midwives, so I've been really lucky."* *LYNN*

There has been much debate about how continuity of care is defined (Sandall, 2004), although no single definition has been widely agreed. The concept of continuity can be provided in a variety of ways, ranging from a system where medical records detailing all pregnancy information are available to all professionals providing care, thus ensuring a continuous plan of care (what McCourt *et al*, 2006, describe as continuity of information) to that provided by

individual midwives, who provide a total package of care to each woman in their caseload, as observed in the birth centre.

Midwives, however, cannot always guarantee to be present at a birth, and need to make suitable arrangements for cover in their absence. The model of care practised in the birth centre ensured that a shared philosophy provided continuity when the named midwife was not available, and this was reflected in the attitudes of the midwives who the women encountered. This aspect was often remarked on by the women, who were complimentary about all the midwives, not only their named midwife. Overall, the women's experiences of antenatal care had been very satisfying, with the attitudes of the midwives and the good continuity of care providing one of the main reasons for this.

Satisfaction with continuity of care has been reported in several studies, including two systematic reviews which looked at randomised, controlled trials comparing continuity of care to more traditional fragmented ways of working, (Hodnett, 2002b, and Waldenström and Turnbull, 1998) Both reviews found that continuity of care conferred a number of benefits for women, as well as increased satisfaction with care. These included less need for painkillers during labour and birth, feeling more supported during labour, and experiencing less intervention. Outcomes for labour and birth in relation to instrumental and operative deliveries, however, remained the same for women who received continuity and those who did not. Although birth outcomes are one way of measuring positive effects of the type of care given, what health professionals see as a desirable outcome (for example, less pain relief or a reduction in caesarean section rates), may not be shared by women, who may have their own views on what is a good or bad outcome.

Closely associated with the concept of continuity was the ability to form trusting relationships with midwives, which, depending on the type of care available could happen over both shorter and longer periods of time.

Berg *et al* (1995) carried out a qualitative study to describe 18 women's experiences of their contact with midwives in a birth centre in Sweden. The birth

centre advocated continuity of care, restricted medical technology, and encouraged the woman's sense of self-responsibility. This care, however, was only available to women in labour, and antenatal care was provided elsewhere, presumably by other midwives. The key findings from the study were that women liked to be treated as individuals, wished to form a trusting relationship with the midwife, and receive support in making their own decisions about care. Being treated as an individual was established by developing a relationship with the midwife, and being familiar with the surroundings (women were encouraged to visit the unit prior to birth). Continuity of care from the midwife during labour allowed for the relationship to develop. Good communication helped the women to feel confident in the ability of the midwife, and being encouraged and supported in making their own decisions helped women to feel in control.

A UK study carried out in Leicester (Walsh, 1999), found that the ten women participants who were able to develop a relationship with known midwives felt that the midwife became a friend to them and their family. Seeing the same few midwives antenatally encouraged this relationship, and the inclusion of partners and other children in care was greatly valued. Walsh had originally sought to establish how women felt about continuity of care, but as his research progressed, found that the relationship between woman and midwife was of over-riding importance. One particular factor singled out by Walsh, that of ending the relationship with the midwife with cessation of care was also observed in this study, as Sarah explained:

*"Your relationship with the midwife is very close, like a friend, but not over familiar either… yeah, we've missed seeing her since discharge."* *SARAH*

Repeated encounters with the same midwife or group of midwives were found to enable a group of 17 women to build up a relationship with the midwife, in a study by Coyle *et al*, (2001), carried out in three Western Australian birth centres. This had the effect of the woman feeling that she was known to the midwife, and that she felt comfortable with her carers. Many of the women in that study had previous birth experiences with more fragmented models of care, where they received care from many different individuals. This had the converse effect than the continuity model of care – women did not feel able to establish a

rapport with the midwife, and did not feel that, for example, her wishes for labour and birth were enabled, as the midwife did not know her, or her wishes.

These aspects were observed in the current study, with Fiona telling how she felt alone and disempowered during her previous labour, and felt that the model of care on offer in the birth centre would provide her with a better experience this time around. Alison also discussed the advantages of having known carers, when she talked about her plans for birth (see p 144).

The birth environment was the main reason that women chose the birth centre, and this theme featured prominently in their experiences of antenatal care. The physical environment, shown in several studies to be important to women, was important to the group of women in this study, and for the same reasons: comfort, convenience and a welcoming atmosphere where partners and family members were included. More important than just the physical environment was the underlying philosophy of care offered to women. Women wanted to feel that they were known to their carers, wanted to develop relationships with their midwives which were based on trust and mutual respect, included continuity and wanted to be fully involved in making decisions about their care. These features have been demonstrated in other studies, which assessed the impact of continuity of care. The midwifery model of care, practised in the birth centre met women's needs, and helped their aspirations for birth by emphasising normality.

### 7.7 Theme Two - Knowledge

Knowledge and its relationship to feelings of control was discussed in the preliminary literature review in chapter two. This theme however, began as a focus on knowledge and its relationship to worries, a common occurrence in pregnancy. During the interviews, women talked about aspects of pregnancy and labour that they found worrying, and what they knew about these subjects. Gaining and demonstrating knowledge was important to the women in this study, and they explored different ways of achieving this. Worries changed as pregnancy progressed, and the way in which women dealt with these was interesting to note.

### 7.7.1 Knowledge and Pregnancy

Having worries about pregnancy was very common; indeed all of the women had experienced some worry or other, which they related during the interview. All women looked for reassurance from the midwife that all was well, and her accessibility and the ready availability of professional advice and knowledge was an important aspect to all women.

By the time of the interview, early pregnancy worries such as bleeding or placental anomalies had resolved, but were still recalled as an important event by the women, as they had the potential to affect the outcome of pregnancy:

*"In the beginning, the placenta was a bit low, so I was worried about having to have a section, as I'd have to go over to.... I'm a real baby, I'm terrible, I wouldn't be no good at that."* *ISOBEL*

As pregnancy progressed, different worries appeared – swollen ankles, or reduced fetal movements perhaps. Women rang the birth centre frequently for advice, even though they were quite aware that sometimes their worries were unfounded. For the pregnant woman, the birth centre had become the focus of all her care, an important part of the local community.

Accessibility due to its physical proximity or by telephone was much appreciated and was in itself reassuring for women.

*"So I feel I've got much more support this time, more back up, and y'know, you can 'phone the unit whenever you want to! So I feel much more relaxed this time."* *LYNN*

Other anxieties were more nebulous and ambivalent as labour and birth got closer. Women were excited about the baby, but at the same time, they worried about birth and the responsibilities that having a baby brings:

*"It's a nervous time umm, I'm really nervous. Here now it's like exciting and nervous at the same time, it's a horrible feeling y'know, can't wait one minute then you're like 'I hope everything's all right'."* *ODETTE*

*"I'm sort of taking it as it comes, but as you get that bit closer its like oohh! I think its more daunting than anything, you say you're going to have the baby, it will be painful…it will hurt. One way or another it's got to come out, that's that, but this*

*responsibility, it's that very thing for 20 years or so. Still, I'll cope with it, everybody does."* *DIANE*

Although Odette and Diane would be first time mothers, these worries were not confined to those who had never given birth. The women admitted to having contacted the unit frequently because of worries, but they did not appear to be overly anxious about pregnancy or labour during the interview, which I felt was something of a paradox. Although this phenomenon was observed, it was not explored in more detail.

The women seemed to have a realistic view of what labour and birth entailed, some from their own experiences, others from those of friends and family, but having enough information about pregnancy and birth was always given prime importance by the participants. They obtained information from a variety of sources, both professional and through the media.

Knowledge was an essential element for making informed choices that started in early pregnancy with screening tests:

*"Yes, there's been a lot of explaining everything that's on offer, she (midwife) have said about it, a lot of information's been given as well, booklets and leaflets and things."* *DIANE*

*"She gave us a pack with all the different blood tests in it, and all what they do, and she explained about why they did them, you know, what all the possible results would be and the outcome of those, and what happened depending on that – it was really clear, and my husband was there as well so knew all about it right from the start."* *VAL*

Sometimes the information was unwelcome, as told by Hannah who had received detailed information and counselling prior to having amniocentesis. This was the downside of making an informed choice resulting from Down syndrome screening. Hannah's risk of having a miscarriage following the procedure was equivalent to the risk of the baby having a chromosomal abnormality and she was informed of this in order to choose whether or not to proceed:

*"Yeah, 'cos we've had to have an amniocentesis y'know, and it wasn't (her own midwife), it was another midwife we spoke to (gives the name). She was really helpful, if anything, she gave us too much information in some ways, but she was really helpful."* *HANNAH*

Other information wasn't quite so difficult to deal with: women frequently asked the midwives questions relating to pregnancy, as was demonstrated by Penny: *"Yes, anything I've asked, the midwife's always explained."*

A few of the women interviewed had attended parentcraft classes at the birth centre, and almost all of the women said they watched television programmes about labour and birth. They demonstrated a realistic and astute viewpoint about the content of the programmes, and which programmes they thought would be most useful to them:

> *"Yeah well, I say I watch them, my mother watches them, and she keeps calling me to see bits of them. I say 'I don't want to know!'... What I find with TV a lot is they cut a lot of it out like, so they show you the bits to keep you watching like, but they cut out the bits that could be the important bits.* *DIANE*

### 7.7.2 Knowledge and Labour

Women like to talk about their own experiences of labour and birth so this made it easy for first-time mothers-to-be like Val, to gain knowledge of labour through vicarious experiences. Comparing herself to a friend helped Val to feel positive, thus creating a feeling of control:

> *"My friend's just had a baby a few days ago, if she can do it I'm sure I can, I think she's a bigger baby than what I am!"* *VAL*

Others also discussed labour experiences with friends to gain a positive outlook:

> *"My friend actually, she had a brilliant labour, she says she'd go through it again, I love talking to her"* *RACHEL*

Some women were more circumspect however:

> *"You can't comprehend what its going to be like, no-one can tell you what its like, it might be better or a lot worse, we'll just have to wait and see."*
> *ALISON*

Women had a good knowledge of what pain relief options were available to use in the birth centre. This allowed them to plan a variety of strategies to cope with labour:

> *"I opted for the pool straight away and gas and air. I don't want Pethidine, but I'll see at the time."* *ODETTE*

*"So I thought I'd try it (TENS machine) this time, you know I'd rather try anything than go down the Pethidine route, I'd like to stay at home longer this time as well as its so close to the unit. I can start the TENS here."* *LYNN*

Coping with labour pain equated to feelings of control for women – Odette went on to say how she didn't want Pethidine, as she wanted to *'be in control'*. Fiona, recalling a previous birth where midwives had tried to get her to lie down, was adamant that this had made labour more painful because she had been denied control, stating that:

*"This time I was gonna do things the way I want to do it y'know, 'cos you sort of get pushed into things."* *FIONA*

Helping themselves to feel positive about labour gave women the sense that they were in control, and gaining knowledge from a variety of sources helped in this. Sarah, telling how her previous birth had prepared her for this time said:

*"I like to absorb lots of information, and I went to classes and learnt lots about how to use the gas and air, moving around and things, and I - you know the more information I got - its empowering isn't it?"* *SARAH*

### 7.7.3 Discussion

A thread running through many of the studies previously reviewed in chapter two is the importance of knowledge to women's feelings of control and the ability to make decisions and choices about their care. There is a need to have some knowledge almost before pregnancy begins, as decision making begins early, with women being offered choices and expected to make decisions about where to give birth and about antenatal screening. Information about pregnancy and birth is available on the internet, in the media, from family, friends and other women, or from health professionals. All these forms of knowledge are different, however, as women themselves are different, and it is left to the woman to differentiate between accurate and inaccurate information.

Knowledge regarding making informed choice during pregnancy was discussed in the preliminary literature review (section 2.5). The women used other sources of information, however, talking about popular programmes on both terrestrial and satellite television, and showing that they were quite astute about how they related the content of the programme to their own pregnancy.

*"I watched one from a birth centre in Surrey the other day, it was good, it gave me some idea of what it would be like in our birth centre."* *GAIL*

The women in this study found that they were given much information by their midwife which helped them to make informed choices, even when this was a worrisome aspect, as that described by Hannah (p 132).

Coping with worrying events, such as waiting for results of screening tests was the subject of a randomised controlled trial carried out by Bennett *et al*, 2006. A leaflet detailing distraction techniques was assessed for effectiveness in helping to alleviate worries for women awaiting results from cancer screening test. The aim of the leaflet was to reduce the amount of worries and intrusive thoughts suffered by women during this waiting period. The leaflet was given to the intervention group of 51 women, and its effect compared to a control group of 48 women. The leaflet was found to be of use for women who were distressed by the wait. This type of information might have been useful for Hannah, whilst she awaited the results of the amniocentesis.

Worry associated with pregnancy is a common entity. Women worry about the baby, and of course, about labour and birth. Raphael-Leff (2001) describes how a woman can be beset by anxiety during pregnancy, sometimes fearing that the pregnancy will go on forever, and at other times wondering if birth will leave behind an empty shell, all her essence being expelled with the birth of the baby. Other worries are associated with the effect of pregnancy on the woman's body image (Affonso *et al*, 1999).

Worry has been shown to have an association with developing strategies to cope with potentially threatening situations, what is described as *"the work of worrying"* (Janis, 1958, p374). In this context, worry is seen to have a functional aspect, and may serve to prepare the person for an event such as labour and birth. Worry can, however, be termed as dysfunctional, where it is associated with anxiety and depression, and interferes with normal life (Affonso *et al* 1999). The women in this study admitted to having many worries, mostly trivial (their words), which led them to contact the midwives. This was a puzzling aspect, as

they had normal, uneventful pregnancies, and the worries were not about labour or birth (section 7.7.1).

Women's levels of worry and how these were related to complicated or normal pregnancy was researched by Homer *et al* (2002). Although the study group of women (159 in total) all had complex pregnancy needs (therefore more potential for worry to arise), they had lower reported levels of worry when compared to women with normal pregnancy. One of the main reasons for this was felt to be a model of continuity of care, provided to the complex pregnancy group. Women with normal pregnancy had fragmented care, and saw many different professionals during the course of their pregnancy. This was an unanticipated aspect of the study, which the authors felt warranted further investigation. The study concluded that listening to and acknowledging women's worries helped to decrease them, and this was facilitated by a model of continuity of care.

This was an interesting finding, which offered a possible explanation for what was described in the birth centre. Midwives always responded positively to women's queries during pregnancy, so the women felt able to contact the unit at any time. Although they did not always speak to their own midwife, they felt that the midwives took their concerns seriously, and the midwives all responded in a way that the woman felt she was known, therefore experienced a sense of continuity.

Women discussed how they obtained knowledge from a variety of sources about pregnancy, labour and birth in the antenatal interview. The largest contribution to the theme of knowledge was associated with methods of pain relief for labour, and developing strategies for labour that they knew would be effective in helping them to cope. Coping is defined by Folkman and Moskowitz (2004: 745) as:

> *"The thoughts and behaviours used to manage the internal and external demands of situations that are appraised as stressful."*

Traditionally, childbirth preparation classes have helped women to develop helpful strategies such as breathing techniques, or positions that can enhance comfort during labour (see section 2.6.1). Additionally, there is some emphasis

on teaching how and why pain occurs, to increase women's knowledge (Escott *et al*, 2004). However, there are other strategies which women can use, depending on the thinking style of the individual. For example, distraction techniques taught in psychoprophylaxis (Anderson and Hughes, 2001). For these women, learning about the nature of pain is not helpful (Baron *et al*, 1993).

The management of pain and anxiety and the relationship to women's antenatal preparation was the focus of a study by Escott *et al*, (2004). This study was carried out in two large maternity units in the north of England, and used two separate samples of nulliparous women who had not attended any antenatal preparation for labour classes. The first group of 23 women were interviewed during the third trimester of pregnancy to establish what strategies they generally used to cope with pain and anxiety (non-pregnancy related). The second sample of 20 women were interviewed within 72 hours of birth, to establish what coping strategies they used during labour.

The study was qualitative, using semi-structured interviews, which were transcribed and analysed using template analysis, a technique described by King, (1998). In this method, pre-defined concepts were developed following a literature review, and these were used to apply coding to the data. The first group of 23 women were interviewed during the third trimester of pregnancy to establish what strategies they generally used to cope with pain and anxiety (non-pregnancy related). The second sample of 20 women were interviewed within 72 hours of birth, to establish what coping strategies they used during labour.

Coping strategies identified were divided into two separate entities: thoughts and behaviours. Helpful strategies were thoughts which included distraction from the pain and self-reassurance by the women, whilst helpful behaviours included adopting more comfortable positions, support and reassurance. Anxiety was dealt with by distractions such as thinking of the baby, or deliberately pushing worrying thoughts to the back of the mind – rather like the technique adopted by Rachel, who felt that she had gone beyond the stage of worrying. Another way of coping, described as comparing oneself to others was also identified. This technique was described by both Rachel and Val, who were heartened by the fact

that friends had coped well with labour, giving them the expectation of also being able to cope.

Unhelpful strategies were thinking negatively, focusing on the pain and feeling unable to cope. Not all behaviours were found helpful by all the women, and some women tended to have negative thoughts that were not helpful to them. Lack of understanding about the nature of labour was associated with more worry. It was here that trust in carers and the support and care received was found to be of most benefit.

The study identified that most women have well developed strategies for dealing with pain and anxiety which are useful in labour, even when the woman has had no formal antenatal preparation such as attending classes. The authors suggest that midwives can discuss these strategies with women antenatally, helping them to develop more positive ways of dealing with the pain of labour, and provide support and help for women during labour. This was consistent with the findings of the study by Spiby *et al* (2003), discussed in section 2.4.

What was clear from the findings of my study was that women had discussed labour with their midwife, even if they had not attended formal classes, and knew of helpful strategies (such as being able to move and change positions freely). Some women had thought of which distraction techniques they would use during labour, and felt confident in their ability to cope. Knowledge and how this related to women's feelings of control was described in several of the studies reviewed in chapter two, for example Green *et al*, 1998 and 2003; Gibbins and Thomson, 2001. This was a factor for both nulliparous and multiparous women in this study.

A different view of the challenges women face was presented by Raphael-Leff (2001: 237), who discussed what she called '*the moment of truth'.* Women have to face the uncertainty of knowing when labour will start and how they will cope, and self-doubts in their abilities to create and finally give birth to the baby. She identified two psychological types of women associated with birth: facilitator and regulator. The facilitator trusts in her ability to birth the baby, both mother and

baby working together in a self-contained process, almost a dream-world, which is private, intimate and ultimately enjoyable. This resonates with the findings of Halldosdottir and Karlsdottir (1996), who describe women retreating into themselves as a method of assuming control during labour. The regulator, on the other hand, has no faith in the natural process of birth, instead, feeling that by being in control of herself and trusting in scientific development and professional care, she can *endure* labour, making it as short and pain-free as possible. The aspect of personal control is central to the regulator's view of labour. Raphael-Leff (2001) was in accordance with the views expressed by Spiby *et al*, (2003) as she suggested that both types of women benefit from realistic preparation for childbirth, including planning for unforeseen events, so that they can adapt their expectations to the type of care that is on offer. It is suggested that health professionals can assist women to have the type of birth they want as far as possible, aided by an understanding of the fundamental differences between the two types of women.

This theme encompassed women's worries about pregnancy and about labour and birth, and showed how they received reassurance and obtained knowledge in order to address these worries. Earlier pregnancy issues were now in the past, though women were able to discuss in some detail the possible consequences that these entailed. This demonstrated that they had developed a good level of knowledge throughout the course of their pregnancy. Their main worry at the time of the interview was how they would cope with the pain of labour, they were in the process of developing strategies that they felt would help them to manage their labour more effectively. Knowledge was the key to women feeling in control.

### 7.8 Theme Three - Anticipating Labour

Women were asked what they expected labour and birth to be like, and what their plans for labour and birth were. All the women interviewed antenatally were in the final few weeks of pregnancy, and labour could be expected to start at any time. This led to a mixture of feelings: those who had experienced birth before used their knowledge to plan how to handle labour this time, whilst first-time mothers were facing an unfamiliar entity. Most women concentrated on the

aspect of pain, anticipating (or knowing) that labour would be painful. In addition, there were elements of fear expressed: fear of the unknown, for example in nulliparous women. Although fear was in some instances related to a fear of pain, it encompassed other aspects, such as a fear of loss of control, usually expressed as '*not being able to cope'.* Women discussed their various strategies for dealing with labour, with a spectrum of ideas ranging from use of pain relief to concentrating on the end result – the baby.

In this theme there was a marked distinction between those who had given birth before and those who had not, and because of this, findings are discussed separately for both groups of women.

### 7.8.1 Perceptions of Multiparous Women

For the women who had experienced labour and birth before, there was no unknown quantity, particularly in regard to how painful labour would be for them. They knew the reality, and could speak from a position of authority about what they expected. It is a commonly held knowledge that the second labour is usually quicker than first time around, a fact that the women found to be encouraging. Dealing with labour pain was anticipated, but it was a known entity, based on their past experience:

*" I was pleasantly surprised that it didn't hurt more than it did"*
*SARAH*

Their knowledge was used to plan pain relief with confidence, knowing that their expectations were realistic:

*"I've learned a few things for this time, Pethidine, I won't touch Pethidine this time, it didn't have a very good effect at all, I didn't know where I was, so I'm staying away from it, I want it more natural this time."* *LYNN*

Sometimes, there were no specific expectations, other than everything happening normally, because it had done so before:

*"Mmmm, I haven't really got any expectations 'cos they're great anyway (midwives in birth centre), I don't think I'll have a problem."* *ISOBEL*

*"It's natural isn't it, it's one of them things that happen."* *JANICE*

Isobel, as well as demonstrating her belief that she would give birth normally, was expressing her faith in the midwives enabling her to labour and birth as she wished – she did not expect to be told what she could or could not do during labour.

### 7.8.2 Perceptions of Nulliparous Women

Pain in labour was the drawback for women who would be first-time mothers: something that had to be endured before the excitement of the baby's appearance. Not all women find labour painful, although most do experience pain: a natural phenomenon arising from the dilatation of the cervix. Although this unknown issue of pain was possibly the most daunting, it was not always worrying to women:

> *(Laughing) "I'm looking forward to it...everybody's saying as its coming so close and that, 'aren't you worried, aren't you panicking a bit?', and you hear all the horror stories about people in labour for four days and that…yeah definitely, I've no worries at all. I mean it's got to come out, so it's no use worrying about it."*
>
> *CAROL*

Women had different approaches, but showed acceptance and stoicism when considering how they would deal with labour:

> *"I just want it done now, I've gone past it in a way, worrying about it, I just want it done."* *RACHEL*
>
> *"The way I look at it, its got to come out (the baby). I get a bit frightened now and then not knowing what the labour pain will be like."*
>
> *ODETTE*

Rachel felt that she had passed through the stage of worrying, and was now hoping that labour and birth were shortly going to take place, Odette had some fear of the unknown, but was seemingly matter-of-fact, and in a later part of the interview stated that she had no worries.

### 7.8.3 Discussion

The women had reached the stage of pregnancy where they had begun to actively think about labour and birth, and to determine their strategies for coping (see section 7.7.2). The ambivalence with which some women approached labour echoed that suggested by Raphael-Leff (2001), discussed in section 7.7.3. Rachel admitted to having had worries about labour, but felt that she had now passed this phase. Odette, Gail, Brenda and Val were both frightened and

excited by the thought of labour, sometimes swinging between emotions, and at others feeling both at the same time. Nulliparous and multiparous women had different approaches which was not surprising, given that the latter group had previous first hand experience, but there were aspects of Raphael-Leff's (2001) description of the facilitator and regulator categories of women to be seen in this study (see section 7.7.3): Isobel, Janice and Carol showed signs of being facilitators, considering birth to be unproblematic and natural, whilst Lynn seemed to fit more into the regulator approach, wanting to control how the birth was managed.

The literature review of expectations and experiences (section 2.4) showed that labour pain featured prominently in women's expectations, and this was supported by the results of this study, being a feature both in the previous theme on women's knowledge, and part of their expectations for labour. This was a particular challenge which the first-time mothers felt they had to face. People who have a strong sense of self-efficacy (Bandura, 1982) are able to successfully deal with personal challenges. This requires the individual to judge how to deal with a prospective situation, by initiating and following a course of action that will have a beneficial effect. Merely knowing what to do is not sufficient. Being motivated to act on the knowledge is also required, (Bandura, 1982). The theory of self-efficacy postulates that the person is able to develop coping mechanisms, providing that they believe themselves capable of carrying out the required behaviour and that this will be successful in achieving what they intended (Maddux *et al*, 1986). In the case of women in labour, these are the behaviours which women think will be helpful to them, and the measure of confidence that women place in the success of these (Drummond and Rickwood, 1997).

A study that aimed to measure self-efficacy for labour was carried out on a group of nulliparous women attending childbirth preparation classes in a midwestern city in North America (Lowe, 2000). The women, in the third trimester of pregnancy were given a questionnaire that measured their self-efficacy. The key findings of the study demonstrated that the level of fear of childbirth had a direct effect on women's self-efficacy. High levels of fear were associated with lower levels of self-esteem, fewer feelings of control, and therefore less self-efficacy

for labour. Western, medicalised models of childbirth were found to reinforce negative psychological attributes, leading some women to becoming increasingly dependent on interventions to help them through the experience of childbirth.

This was an interesting conclusion, as women going to the birth centre were opposing a model of medical intervention, which meant that they could not have epidural analgesia on site. It seemed that they were confident that they would be able to deal with labour pain, even though it was an unknown entity[16]. Although women who had experienced birth previously were at an advantage, all women had reached the stage where they were anticipating labour and finding strategies to be helpful, a factor found in other studies. Pain was the greatest factor to be considered for nulliparous women, and was also discussed by multiparous women.

### 7.9 Theme Four - Making Plans

Planning to give birth in the birth centre necessitated the midwives discussing the possibility of transfer with the women. Women had their own ideas about what they planned for labour and birth, depending on how they felt they would cope with this. Midwives discussed birth plans with women, and the normal pattern of labour. During the antenatal interviews, although women mentioned the possibility of transfer, their plans were for normality; disaster plans were never articulated. Postnatally, the subject of plans again arose, this time telling how being transferred would affect women's plans for future pregnancy.

#### 7.9.1 Birth Plans

Making plans for birth was closely related to expectations for labour. Contained within the hand-held records were several pages dedicated to the formulation of a birth plan. I was interested to see if women made use of this section of their notes, and if so, what their plans included. To begin with, women gave a brief account of what they wanted their birth to be like. It was natural that women hoped for a short, easy labour, and two of the women interviewed began their plan with this ideal:

[16] One woman in the study – Maria - was transferred in labour as a result of wanting epidural analgesia.

*"Um ... I'm hoping I'm going to go in and everything's going to be fairly sort of relaxed and straightforward. I'm going to try to be more relaxed. I'm a bit older and I know what to expect a bit more, and hopefully then everything will be straightforward and I'll have him and everyone will be there and basically that's it really, I don't really know."* *HANNAH*

*"I'm hoping this time I'm going to be just in and out, have some pains, go in, have the baby and come home straight away after."* *NATALIE*

Both Natalie and Hannah had other children, so perhaps their plans for an easy birth were not too unrealistic. Although the overall feeling was one of optimism about the impending birth, women experienced ambivalent feelings. There was excitement – looking forwards to the baby, but this was tempered by some apprehension. Odette said that she was sometimes frightened about the thought of labour, yet was at the same time looking forward to it, and denied feeling nervous.

With a few exceptions (Diane and Isobel), most women had some ideas regarding a birth plan, it was something they had considered and discussed with partners, husbands and their midwife. It was therefore quite surprising to find that none of the women had written the plans formally. Alison was a good example of this as she had strong ideas of what she did and did not want to do, even though she was also firmly keeping her options open:

*"I'm keeping my mind open because you can't plan, you haven't got a clue y'know, probably I'll end up in the car screaming all the way to (DGH) for an epidural, but the plan is, stay at home for as long as I can, and keep active, hopefully my husband will be able to come back (from working away), my mum's here and I've got my TENS machine, I'll be using that for as long as possible, then go up to the unit, use the water as pain relief and see how it goes, if I want to give birth in there, I might want to get out, I don't know. Really the only thing I don't want is I don't want to be lying down if I can avoid it you know, perhaps squatting, working with the gravity, but then I might want to lie flat on my back 'cos I can't stand the idea of movement!"* *ALISON*

Alison went on to explain why she had not written out her plan:

*"I haven't really written a birth plan, I got it in my head and everyone knows what I want, but I think you can get upset if things start to go wrong, so I'm going to be prepared for that, I might have to go to hospital, I might not be able to bear the pain."* *ALISON*

This confirmed that as pregnancy neared the end, women harboured both hopes and fears about labour. An interesting factor was that although the women had considered the possibility of transfer to the DGH, their birth plans were all about the birth centre. Transfer was mentioned, but never discussed in any detail:

*"Yeah, I know if anything did go wrong, we're not too far from the hospital (DGH) anyway…not that I think that will happen anyway."* PENNY

As the women chose to view labour and birth in such a positive way, further exploration of this sensitive issue was difficult at this time.

### 7.9.2 Future Pregnancy Plans

During the postnatal interviews, however, the topic was discussed quite openly, with women explaining how the effects of being transferred would affect their future plans for pregnancy and birth. Out of the five women, Lynn had now completed her family, and Alison would have less of a choice following caesarean section. Ellen, Sarah and Penny all had individual views.

Ellen had lost confidence in the idea of the birth centre, wondering what would have happened if she had not been transferred prior to the fetal distress developing:

*"I think that, if I was planning another baby, not that I am, I would probably go to the DGH anyway. I'd probably have a great delivery next time, but even so… I'd want to avoid that transfer."* *ELLEN*

Her summing up of the birth centre experience, however, reflected how much she appreciated the care that she had received, and the choices that this type of care offered:

*"I do think it's a great experience there (birth centre) anyway, 'cos they do things like the birth pool and things, just the fact that it all seems to be left to you, that's the really best thing about it there."* *ELLEN*

Penny sums up the situation quite succinctly:

*"Its all your emotions and everything, I didn't really think of that side, I just thought about pain (labour), but your hormones, you just need somebody."*
*PENNY*

Empowered by her experience, Penny found the future to be much less complicated:

*"You know, I'm lucky that I've got close family, but also all the people (midwives) who've dealt with me all the way through, I am glad, I will do it again sometime. I've got my contacts!"* *PENNY*

### 7.9.3 Discussion

As the time of birth grew nearer, women began to entertain the possibility of catastrophe or disappointment, though did not want to dwell on this aspect. Almost all of the women interviewed antenatally tempered their aspirations for normal birth by adding phrases such as that used by Gail: "*You never know which way it's going to go do you?"* This showed that women had a realistic view of labour and birth, knowing that sometimes, medical intervention was needed, although acknowledging that the birth centre dealt with normality. This focus on labour and birth being a normal event was a feature of the midwifery model of care, but the midwives also had to discuss the possibility of transfer with women, as this formed part of the process of making an informed choice to give birth in the birth centre. Towards the end of pregnancy, women began to make their birth plans.

Most women have preferences for labour and birth. These preferences may be stated in the form of a birth plan, which may be simple or complex, in written form or told verbally. The content of the birth plan will depend on women's expectations for labour and birth (Brown and Lumley, 1998), and where the woman obtained the information when developing her birth plan. A '*Google*' search of the internet for 'birth plans' revealed 1,470,000 hits. The first page included, for example, The NHS Direct website [www.nhsdirect.nhs.uk] which advises women that a birth plan can explain their choices for managing labour and birth as these may be difficult to articulate once the woman is in labour. The website goes on to discuss some factors which women might like to consider, a theme which is repeated on other sites such as [www.tesco.com] or [www.Mothercare.com.] Popular items include the place of birth, pain relief, environment, companions, and birthing positions. Women are advised to discuss options available to them before formulating a birth plan, so that their choices reflect the options available to them. This is good advice, as it helps women to develop a clear idea of what they want, and to share this with carers, and the supporters they will have with them for birth (Brown and Lumley, 1998).

Although women may access information through the internet, (see section 2.5) it has been found that many birth plans include information which is outdated, leading women to formulate a birth plan which does not address the routine practices of their maternity carers (Kaufman, 2007).

The concept of the birth plan arose in the 1970s as a response to the medicalisation of childbirth that dominated women's experiences at that time (Simkin, 1980). Simkin, a childbirth teacher and doula developed the birth plan in the United States to enable women to avoid unwelcome intervention, and this was later reputedly introduced into the UK in the 1980s by Kitzinger, well-known as an advocate for women and childbirth (Nolan, 2004). Birth plans became increasingly popular as a means for women to be able to state their preferences in advance of labour, but were not always well received by professionals, who perhaps saw them as a means of moving the balance of power from themselves to the woman. This was unwelcome in some models of care, with women's choices being at odds with the system of care on offer (Lothian, 2006). Simkin, (2007) discusses how her ideas about birth plans, intending to aid communication between woman and professional, were met with suspicion and mistrust in 1983 when they were first described in the journal *Birth*, being denounced as a fad by a British social scientist, who felt they represented a lack of trust between woman and birth attendant. Simkin (2007: 49) comments:

> *"The birth plan has continued to create tension in client-caregiver-nurse relationships over these 27 years, and the differing reactions by practitioners and recipients of obstetric care to birth plans represent the age-old gulf between them."*

Since this first introduction, birth plans have evolved somewhat, and where once they favoured normality and little intervention they may now often include a wish for caesarean section, or epidural analgesia. These types of birth plans, according to Robinson (1999) are not met with a hostile reaction from professionals, as they reflect the type of birth that is consistent with their own beliefs. Lothian (2006) suggests this is because professionals find it difficult to acknowledge that sometimes, women's views about labour and birth are different from their own, and there is a failure to empathise with the needs of the mother.

Women's perceptions of birth plans were explored by Whitford and Hillan, (1998). They wanted to find out if primigravid women in Dundee, Scotland had made a birth plan, and how they felt this affected their labour and birth. They found that of the 143 women, 90% (129) had made a birth plan, which they felt was useful when considering options prior to labour. Half the women did not feel that it helped their sense of control in labour however, and this was attributed to the lack of attention paid to birth plans by carers.

In the current study, most women had some plans for birth, though none had formulated a written plan. Their reasons for this varied. For example, some women felt totally confident that the midwife would enable them to do what they wanted, or they had a good knowledge of the type of care on offer in the birth centre so were realistic in what they expected, and what choices they were able to make. All of the women expected the birth centre midwives to accommodate their wishes, and it was apparent that the women had discussed their plans with the midwife, even if they were not formally recorded[17].

By choosing the birth centre, the women had already begun to plan for birth, as certain facilities such as epidural analgesia were not available there. Although the women in this study had decided what they wanted from labour and birth, it was clear that this only extended to the birth centre. There were no plans mentioned if transfer was necessary. Whilst this was not unsurprising in some ways, after all, the course of labour and birth is not predictable, and it was therefore impossible to speculate about what might happen, the women seemed resigned that decisions and choices would be taken out of their hands if they needed to be transferred. This phenomenon is described in an anecdotal story where a woman is admitted with a labour complication and feels that her birth plans are now unachievable (Simkin 2007: 50):

> *"When her nurse asked for her birth plan, the woman did not want to show it to her, replying, ''It's too late. It's already fouled up.'' The nurse kindly persisted, and the woman finally relented, tearfully handing over her birth plan, with, ''It's just a joke now.'' The nurse looked it over and said, ''There's a lot here that we can still do."*

[17] The midwife might make a note in the woman's records if she had specific wishes that were unusual and might require some forward planning, such as the arrangement of the birth room.

As in the anecdotal story, Alison, in this study, found to her surprise that the staff in the DGH continued to respect her wishes:

> *"I felt that I had choices; they were asking do you want to do this or that. It was my choice to have my waters broken, and they asked if I wanted to get up and that, so the whole time it was very much my choice of what I wanted to do, and I think they tried, I mean obviously they knew I was from the birth centre, and I was trying to avoid taking anything, so they were checking with me what I wanted to do, and they let me go as long as I possibly could."* *ALISON*

This was important to Alison, and helped her to feel that everything possible had been done to accommodate her wishes, even though she had a caesarean section.

Of the five women in the study who gave birth in the DGH, two had considered the implications of the transfer for a future pregnancy. The two women had different reasons for being transferred, but would be eligible to have care in the birth centre[18] next time if they chose: Ellen, transferred for raised blood pressure went on to develop fetal distress and Penny progressed slowly in labour.

Ellen had lost confidence in the birth centre system of care, as she had been frightened by her experience of fetal distress. She felt that she had put her baby at risk, and that she was lucky that the distress had developed whilst she was in the DGH, rather than in the birth centre, where a forceps delivery could not have been carried out. Ellen would choose to give birth in the DGH next time, basing her choice for a subsequent pregnancy on the need to avoid being transferred. This was consistent with the findings of Weigers *et al* (1998, section 2.3), who found that primigravid women in Holland lost confidence in having a subsequent home birth, if they were transferred from home to hospital during labour.

Penny, in contrast, would have no hesitation in choosing birth centre care in a subsequent pregnancy. Although she was distressed at having to be transferred, she felt confident that the benefits she received from her care outweighed the risks that transfer might again be necessary:

[18] The selection criteria for the birth centre depend upon the reason for transfer and the outcome of the birth. Both Ellen and Penny could go to the birth centre in a future pregnancy if they wished.

*"I just feel lucky that I've known who I've known, they've helped me all the way through."* *PENNY*

This was an area that would have merited more exploration. Both women expressed how much they felt supported by the care they received in the birth centre, and Ellen also felt that she was not of particular risk from needing operative delivery, or experiencing fetal distress in a subsequent pregnancy. Whilst it was understandable that she felt worried about the possibility of fetal distress occurring again, I felt she would have benefited from a full explanation of the circumstances and consequences of her experiences during this birth, which she stated she did not receive.

Ellen said that she did not currently plan to have another baby, and although this might have been her decision before she embarked on this pregnancy, this is also a common occurrence where women have undergone operative or instrumental deliveries. A study in Dundee of 283 women who had an operative delivery in theatre (Caesarean section and instrumental delivery) showed that approximately one third of women (91) wished to avoid a future pregnancy as a result of their birth experience. A fear of childbirth was cited as the reason for this in almost half of the women surveyed (Bahl *et al*, 2004). This reflected the findings of an earlier study undertaken by Jolly *et al*, (1999), where 222 women responded when asked about undertaking a future pregnancy. Of 172 women who had either a caesarean section or instrumental birth, 84 were frightened of pregnancy five years later, this compared to 15 out of 50 women who had a normal birth.

A qualitative study by Murphy *et al,* (2003), addressed some of the issues that may have been pertinent to Ellen. The UK study looked at a sample of 27 women who had had undergone an operative delivery. In that study, operative delivery included caesarean section, and instrumental delivery carried out in theatre (as in Ellen's case). Consistent with the findings about birth plans (section 7.9.1), women in the study had not really considered this as a possible option for birth. This left them feeling unprepared for an instrumental delivery. Despite discussion with medical and midwifery personnel prior to discharge women were left feeling unclear about what had happened and the consequences

of this for future pregnancy, and would have welcomed the opportunity for a further review.

Most women in this study had definite ideas about what they wanted to experience during labour and birth, with their choices being determined by the care on offer in the birth centre. They were confident that the birth centre midwives would support them in their choices, so did not feel the need to write their birth plans out formally. What the women revealed, however, was that their plans only related to the birth centre. Although they were aware that sometimes medical intervention was warranted, and that this would necessitate transfer to the DGH, their plans did not go beyond this point. Women were affected differently by being transferred in labour, and this in turn seemed to affect how they anticipated planning for another pregnancy. Explanations about instrumental delivery and the consequences of this for the future were not given by medical staff prior to discharge, even though this has been shown to have an effect on women's future reproduction.

### 7.10 Theme Five - Women's Birth Stories

Birth stories are a way in which women disseminate and obtain knowledge about childbirth (Kirkham and Perkins, 1997). Telling the story of one's birth experience is a common phenomenon, and it is to be expected that in the act of telling the birth story, refinements are made, some situations being played down, others exaggerated, like any other story that is told a number of times. The women were already familiar with the concept of birth stories, as they had featured antenatally as a way of women obtaining knowledge (section 2.5). Now it was the turn of the women in this study to tell their own story.

For the women being interviewed postnatally, some time had passed since the birth, giving them the opportunity to become practised in the telling of their story. There is no way of knowing if the story given at interview was the same as that told to family and friends, or details added specifically for the interview, but the women's overall knowledge was impressive. When telling of their experiences, the clinical details that the women knew, and their analyses of what

happened to them during labour and birth were striking. (See appendix 15, interview transcript, Alison)

There were three separate elements to this theme: telling the story, meeting the challenge of labour and birth, (where women discussed their experience and related how this measured up to their expectations), and their feelings about transfer to obstetric care, (and how they were affected by this at the time, and since the birth). Their stories incorporated experiences, feelings and interpretation of events, and included information gleaned from partners, relatives and midwives who were present. Of the five women, Lynn and Sarah were transferred in the late antenatal period, and Penny, Alison and Ellen during labour. The reasons for women to be transferred, when this took place and type of birth are summarised in table 9.

**Table 9. Reason for Transfer and Type of Birth (post-natal interviews).**

| Participant | Reason for transfer | When transferred | Type of birth |
|---|---|---|---|
| **Alison** | Slow progress during 1st stage of labour | In labour (5cms dilated) | Emergency LSCS |
| **Ellen** | Raised blood pressure during 1st stage of labour | In labour (3cm dilated) | Forceps in theatre |
| **Lynn** | For induction of labour | At 41+ weeks gestation | Ventouse, following induction |
| **Penny** | Slow progress in 1st stage of labour | In labour (9cm dilated) | Normal |
| **Sarah** | Personal choice | 39 weeks gestation | Normal |

### 7.10.1 Telling the Story

The women needed little encouragement to tell their stories. A general prompt such as "*Tell me what happened?*" gave the women the chance to relate their birth story. Alison in particular could recount almost every detail of her labour:

> *"Ummm, oh I think I knew. I think I knew when, I mean, if I was 3cm on the Friday and then after labouring all day on the Sunday and having that exam at three in the morning and she (midwife) said I was still 3, I thought 'well there's something going on', and then I was having such hard contractions, when they examined me at eight I thought I had to be at least 5, and they said I was still 3, and I thought 'its not happening, nothing's happening', so I'd kind of worked it out already, I knew myself that, at that point I knew I'd have a C Section."* *ALISON*

Alison, very well read in the antenatal period, had discussed her labour progress with the midwives, and knew exactly what was happening to her. Ellen, on the other hand, relied on her husband and the attending midwife to fill in the gaps, when an emergency arose, which necessitated a quick forceps delivery to be carried out:

*"To be honest I don't think I could take in what they were saying, I didn't know they were doing a forceps – they might have explained to Ryan."*
*ELLEN*

It seems strange that Ellen did not know what was happening to her, but at this point, she was afraid of the consequences to her baby, and affected by the air of urgency in the staff around her. She was completely focused on her baby; nothing else mattered. Ellen continued:

*"It was just a feeling of pressure. It was explained after, the midwife was lovely, she was really nice and helpful."* *ELLEN*

Taken at face value, the women's stories included decision-making, choices, the need for transfer and medical intervention, all told with equanimity and illustrated by such as:

*"I didn't get my waterbirth, but never mind. It doesn't always go to plan."*
*LYNN*

A little judicious probing encouraged the revealing of deeper, underlying feelings, in the following instances, disappointment, for Lynn and Penny:

*"Very disappointed, I'd set my heart on going to the birth centre, and I kept thinking on Sunday night, 'its going to happen', but it didn't."* *LYNN*

Penny was more emphatic: "*Gutted, I was just gutted!"*

Alison, on the other hand, chose not to reveal what she felt when she knew transfer was imminent, discussing instead how she felt about the birth:

*"Yeah, I wasn't disappointed, I think when they 'phoned the registrar, I expected to go straight in for a section, but they let me carry on labouring, y'know, give it my best shot, and if I'd gone in straight for a section I'd have been wondering if we could have done something else, so I wasn't disappointed, in the end she just wasn't going to shift."* *ALISON*

The women gave an overall sense of resignation and acceptance of events:

*"We tried everything, she just wasn't moving, but never mind, she's fine."*
*LYNN*

Penny, however, expressed her disappointment more clearly:

*"I was really gutted as I'd planned for the birth centre, but I'm just accepting it now, everything turned out ok."* *PENNY*

There was an underlying implication in all the stories that personal feelings and experiences should be set aside as the baby was healthy, although the women skilfully avoided this particular aspect.

### 7.10.2 Meeting the Challenge

The first-time mothers had expressed anxiety about how they would cope with the pain of labour – this was seen as being their biggest challenge in the antenatal interviews. The women now related how they had met the challenge.

Penny had needed more pain relief than she had originally planned, but was self-deprecating about this:

*"Umm…it was worse than I expected, but the delivery was actually better than I thought, better than the labour…. I was a baby with the pain, I knew I would be!" (laughs)* *PENNY*

She went on to explain further:

*"Before I went into labour, I planned to go as far as I could without pain relief, have a water birth if possible, but I just got in there (pool) and thought 'no I can't do this'." (laughing)*

Although she had needed pain relief, Penny was not unduly worried: this had not made her feel a failure. In fact, experiencing this rite of passage seemed to have bolstered her self-confidence, in comparison to how she appeared antenatally. The reality of dealing with labour was perhaps not as bad as the women had anticipated, and for the other two first-time mothers there was a certain pride in not needing much pain relief, as told by Ellen and Alison:

*"To be honest with you, the pain wasn't too bad."* *ELLEN*

*"I went through the whole night just on the TENS machine, and I think I was so totally concentrating I forgot there was any other kind of pain relief, you know."*
*ALISON*

Lynn, having had labour induced, was surprised by how quick the process was this time around:

*"My contractions had started but I was coping with them, so I thought, y'know, it was going to take forever, and then all of a sudden I felt like I wanted to push…it was so quick at that stage"* *LYNN*

In comparison to an issue that had occupied women greatly antenatally, the women did not have much to say about this aspect of labour. Having met this challenge, the women found that they could cope, and so had moved on to the next obstacle to be overcome, that of transfer.

### 7.10.3 Experiences of Transfer

Penny, Alison and Ellen found themselves thrust into a different situation, when medical intervention was needed. From being cared for solely by midwives in the familiar birth centre, they now faced the journey to the DGH, and into what was for them, unknown territory. First of all, the women had to agree to the need to transfer, and as we have already seen, this was disappointing for the women. Of course, knowing and accepting that transfer was inevitable did not mean the women reacted positively when transfer was suggested:

*"But I was like, 'Oh, I don't want to go over there' (DGH), 'cos I'd gone through all of it (labour) in the birth centre."* *PENNY*

The ambulance journey then had to be faced. Travelling by ambulance can be an unpleasant experience, and being in labour, and knowing that labour is not progressing normally, or there is another problem worsen these feelings. All the women's uncertainties were brought to the fore. The journey was short, (7 miles, a time of approximately 12 minutes) but physically uncomfortable. Knowing that the journey was necessary, the women took this very much in their stride. Trusting the judgement of, and being accompanied by, their attendant midwife seemed to play a large part in this, even though the midwife had to hand over care to the DGH midwife following transfer:

*"Yes, she (midwife) was apologising to me, but at the end of the day, she was doing what was in my best interests, she came over with me."*

*PENNY*

*"It was uncomfortable, but there were two midwives in the ambulance with me, and a student, so that was good, and the ambulance journey was…a bit uncomfortable."*
*ELLEN*

Alison found the wait for the ambulance to be the worst part:

*"I had a good hours wait for the ambulance to come and get me. It was the longest wait for anything"* *ALISON*

The physical and emotional drama of the transfer can sometimes speed up labour and this happened to Ellen, although she found it difficult to believe:

*"When I left the birth centre, I was 4cm, and when I got to the DGH I was 8cm, they seemed to say that the ambulance journey, all that jigging around and the bumps and everything seemed to do something."* *ELLEN*

Although Ellen was sceptical, Penny was more accepting that this might have helped labour along:

*"As soon as I got over there I felt the urge to push, as soon as I got over."*
*PENNY*

Indeed, Penny went on to have a normal birth soon afterwards, but Alison was not so lucky. During the time taken for transfer, Alison had also made some progress, and so was encouraged to carry on and see if she could progress by herself:

*"So I got to the hospital, and then they examined me about…. And I was 5cm, so by then we thought maybe something is happening after all."*
*ALISON*

### 7.10.4 Discussion

Childbirth is a profound experience for many women: it forms the 'rite of passage' to motherhood, which will forever change the woman's perception of herself, and her place within society (Pines, 1972). It has been described by Raphael-Leff, (2001 : 375) as a "*postnatal reintegration of personality and social roles*". The formulation of a birth story, which captures the essence of the experience for the woman, is a part of this process. Women like to share their birth stories; an internet search can reveal millions of entries[19] from women who allow others access to their experience. This sharing of birth stories creates a

[19] Using *Google*, and keying in 'birth stories' revealed over 2,500,000 hits, (accessed 21.6 08)

common bond between women, as although each birth is unique, others share elements of the experience:

> *"It was the same for Cleopatra, for Maria de Medici, for Anna Magdalena Bach and Sophia Tolstoy and Sophia Loren – and Eve."*
> *(Sorel 1984 : xvi)*

In telling the story, the woman engages with the listener and invites them to share in the experience. The listener may empathise with the story, having had her own experiences, or may want to experience vicariously what it was like for the teller, described by Frank, (2000 : 361), as a "*glimpse of what it means to live informed by such values."* It has been suggested that women who have no experience of birth, listening to birth stories in order to increase their knowledge, do so in a way that may affect their expectations. If the experience sounds acceptable and the ideals are similar to their own, then they may seek a similar experience (Savage, 2001).

One facet of stories told today is that they may be grounded in a medical model of care for many women, as this reflects the type of care that they receive. This is thought to be disadvantageous to women listening to the stories, as they might be unduly influenced into thinking that birth has to be of a high-tech nature, (Farley and Widmann, 2001). This stance is supported by Couch, (2006), however, it could be argued that negative stories have always existed in the form of 'old wives tales', usually inaccurate and told solely for the purposes of instilling fear (Kirkham, 1997). Women evaluate their ability to cope with labour based on previous or vicarious experiences (Drummond and Rickwood, 1997), described by Bandura, (1982) as a self-efficacy model (see section 7.8.3). But birth stories are more than just factual accounts: they tell the listener of the cultural environment where the birth took place (Kirkham, 1997). This may give the listener knowledge of what she can expect, when she too is in labour, or for the researcher, can allow the interpretation of events from different viewpoints.

The stories of the women in this study reflected their knowledge of events and the interpretations they were able to make of the information they had. There was a difference in the way they obtained information, as this was now from

first-hand experience, and from discussion with the professionals involved in their care, perhaps moving between the procedural and constructed knowledges described by Belenky *et al*, (1986), discussed in section 2.5.

Information was sometimes lacking, as in Ellen's case, or recited in minute detail, as in the case of Alison. This was a reminder that midwives can also learn from listening to the birth stories of women; looking at birth from the other side. There is a difference between a woman's story and the professional account contained in midwifery or medical records. Both accounts are valid, but each reflects a different purpose: the mother sharing her experience of the transition to motherhood, the midwife describing the experience in an accepted terminology (Kirkham, 1997). A midwife attending a woman in a professional capacity is privy to both accounts, and for this reason, midwives play an important role in helping women to gain a clear understanding of the events of labour. Part of normal postnatal midwifery care is to help the woman gain a fuller understanding of labour and birth by discussing her birth story (NICE 2006).

Antenatally, women expressed fears about coping with labour. These were mainly associated with fear of pain, particularly in first-time mothers, and fears of losing control or '*not being able to cope'*.

Although women had a lot to say about this aspect in the antenatal period, they were now quite circumspect about it; the reality of birth, not the anticipation of it being the subject of the birth story. The reality for women interviewed postnatally was different to their expectations. In the matter of pain relief, women felt that they met the challenge of labour and coped well. They took a certain pride in their abilities. Penny, although needing more pain relief that she had initially anticipated, seemed to be accepting of this. Ellen and Alison stated that the pain was not as bad as they had thought. All three women felt that they had managed their pain relief in a way that was appropriate for them, and this therefore was a positive outcome. This is consistent with the findings from a study by Lavender *et al*, (1999), where the information from 412 respondents showed that individual needs for pain relief varied, but adequate, appropriate pain relief was valued by all women. Pain is only one aspect of labour, however,

and for the women interviewed postnatally, experiences of being transferred featured much more in the interview (discussed below). Although meeting the challenge of labour had occupied women greatly in the antenatal period, it seemed that this was now passé: women faced a new challenge – that of being a mother.

The physical aspects of transfer were mentioned by the women, and were generally found to be inconvenient if not a little unpleasant, but the women retained confidence in their carers, and in the situation. This was different from the experiences of women in a transfer group described by Watts *et al*, (2003). Here, eight women interviewed after transfer felt insecure and uncertain when complications arose, one woman feeling that she was *'going to die along with my baby'* (p 111). In that study, the unit had recently changed from an obstetric to a midwifery-led service, and women wanted the reinstatement of a full obstetric service, which they felt was equipped to deal with any complication.

The emotional aspects to the transfer, however, were something that the women had strong feelings about. Both Lynn and Penny told of their disappointment in knowing that birth would not take place in the birth centre as planned. Lynn, knowing that she needed induction of labour due to post-maturity, was given as much choice as possible under the circumstances, which helped her to accept the decision for transfer (for example, she made the choice of when induction would take place, and whether or not to have a membrane sweep).
For Penny, Ellen and Alison, complications arose in labour that necessitated transfer, and although they could have refused to go to the DGH, they were given a full explanation of why transfer was necessary, they trusted the midwives in their professional judgement and so were able to give informed consent to be transferred. These situations reflected joint decision-making by both woman and midwife, identified with positive emotional responses in research by VandeVusse (1999). The women felt that supportive care had continued from the DGH midwives, which was appreciated.

Importantly, the findings in this study upheld the recommendations from Walker *et al*, (1995), Creasy, (1997) and Waldenström, (2004) who explored the effects

on women of transfer in labour (see preliminary literature review, section 2.3). These studies were the catalyst for this research, finding that adequate explanations allowing women to accept the need for transfer and supportive care which enabled feelings of control to be maintained by the woman were key to alleviating feelings of disappointment, and to continue feeling in control.

In this study, midwifery care was seen as supportive in both the birth centre and the DGH, allowing women to make informed choices about their care, even when in labour. In going back to the original research question to establish why women were dissatisfied with their care following transfer, it appeared that the midwifery care given to women was appreciated. Whilst women expressed disappointment in having to be transferred, this disappointment was not in the care they received from midwives, who they felt continued to give them the support they needed at that time.

The birth story, first discussed by women in terms of listening to others, was now a reality for these women. Their stories were informative, and demonstrated their knowledge and understanding of events in labour. A common theme throughout the stories was that of midwifery support, both prior to, and following transfer to, the DGH, which was an important finding for the study. The women accepted the need to be transferred, although four out of the five women explained that this had led to disappointment in not having their baby in the birth centre. (The reasons for this are discussed in more detail in theme seven). Labour had been less of a challenge than they had feared, and any pain relief used by the women was found to be effective, allowing them to remain in control of themselves. Although giving birth in the DGH was not the women's original choice, they all expressed the desire to move forwards rather than dwell on their disappointment, justifying this thought by concentrating on the positive outcome of the birth: a healthy baby.

### 7.11 Theme Six – Experiences of Care Following Transfer

The three women who had care transferred to an obstetrician during labour (Alison, Penny and Ellen) experienced their first contact with medical staff and midwives working in the DGH. Experiences of care were varied, with both good

and bad experiences described. Lynn, transferred for induction of labour, developed complications during the birth that necessitated receiving medical care. For all four women, obstetric care was now incorporated into their experience, and this contrasted with the midwifery care that they had become used to during pregnancy. One aspect, which showed the difference between the medical and midwifery models of care, was the element of decision-making. Prior to this point in pregnancy, all had been normal, with women making their own decisions based on personal preferences and the choices that were available to them. Now, various complications arose which meant that choices were much more limited, no longer available, or perhaps never offered:

*"There wasn't a choice really, I put myself in the hands of the professionals at that point, I thought that was for the best."* *ELLEN*

Ellen expressed her acceptance of the situation, that her baby was becoming distressed, and that she needed specialist help. She was, however, handing over all her autonomy to *'the professionals'* (doctors), whom she assumed would make the necessary decisions with regard to both mother and baby's best interests. Ellen had willingly gone along with whatever decisions were made in the interests of her baby, describing how she was unable to process what was happening to her at that time:

*"To be honest, I don't think I could take in what they were saying, I didn't know they were doing a forceps."* *ELLEN*

It was interesting to note that the doctor who carried out the forceps delivery did not seek to explain the situation to Ellen either before or after the event. Ellen's encounter with the doctor is described on p 162.

Lynn had a different experience; she had laboured quickly, but was unable to give birth herself:

*"She just wasn't moving, she was back to back*[20] *as well, so I just couldn't push her out in the end. So two hours and twenty minutes later he (doctor) decided a Ventouse, so it was very quick in the end."* *LYNN*

[20] Lynn was describing an occipito-posterior position of the fetus, where the back of the fetus' head, the occiput, is positioned in the sacrum of the mother's pelvis. This is commonly associated with slow progress during labour or birth.

Again, the decision was taken by the doctor with no discussion or explanation. When asked if she felt she was given the choice, Lynn responded:

*"I think I was getting to the point where I was exhausted, I just wanted some help, so yes, I didn't really mind at the end, I needed some help I think."*

*LYNN*

Lynn undoubtedly needed help in giving birth, and knew this herself, however she felt she had to go along with the doctor's decision. By saying that she '*didn't really mind*', she was showing her agreement with the decision, and accepting that it was made without any consultation with herself. Whether or not she would have liked to be involved in the decision was not clear.

Alison felt more involved in the decisions surrounding her care, and when the decision to go for caesarean section was finally made by the obstetrician, the reason for this decision was made clear:

*"Yes, I felt that I had choices; they were asking do you want to do this or that? ... They let me go as long as I possibly could until the end when the specialist came in and said 'Nothing's happening, and we need to go to theatre.' "*

*ALISON*

Alison had no further options at this point, however, she felt that she had been given every opportunity to try and give birth normally, and had received encouragement and support from all the staff involved in her care.

The staff in the DGH encompassed both male and female doctors, whilst all of the midwives and support workers were female. Both Penny and Lynn discussed the doctor's gender as it was felt to be an issue:

*"All the women were sympathetic, but that doctor's a man, I'm sure that was why…he gave me a row for pushing, but I said 'I need to!' My body just couldn't stop, like."* *PENNY*

Penny wondered if the doctor being male had made a difference, but for Ellen, the doctor was female:

*"You know she was shouting at me and that, I know they've got to bully you to do certain things, but there are ways and means, and she wasn't…she didn't have any sort of bedside manner at all, even after he was born, during the stitches ... there wasn't just any nice ways about her at all."* *ELLEN*

Unfortunately, for these two women, whether the medical staff were men or women made little difference to the way in which they were treated. Both Penny and Ellen had more to say:

> *"I dunno, in labour, I know he done his job at the end of the day, but he had no emotional attachment, he had no consideration for me, he felt distant, I was just like a piece of meat on the table."* *PENNY*

> *"She wasn't the nicest of people, you know everyone wants their baby to be special, to be perfect, but it just seemed the sort of thing she had to do, whereas everyone else was making it special, she just wasn't like that at all."* *ELLEN*

The two women felt unhappy with their perceived inhumanity of the doctors. Further probing was necessary to ascertain if the women felt that midwives had acted as their women's advocate. Ellen felt the midwife was concerned about the doctor's attitude, and had said she would take steps to address the issue:

> *"The midwives did say that they could request for this doctor not to come back to the hospital."*[21] *ELLEN*

In the minutes following birth, women want to feel that the moment that is so special and of course, unique to them, is special for others who are present. One of the joys of being present at a birth is to share in this, but for the two women, the aloofness displayed by the doctors was hurtful. Apart from the two doctors described by Ellen and Penny, DGH staff were generally found to be helpful and supportive, and the women appreciated the care they received from midwives and doctors who were previously unknown to them:

> *"The midwife was lovely, she was really nice and helpful."* *ELLEN*

### 7.11.1 Discussion

A medical model of healthcare has prevailed in Western societies for many years (see section 4.2). Entering a hospital for treatment commonly seems to confer a surrendering of individuality; people may revert to 'the professionals know best' philosophy. In the past, this was attributed to people being unwilling to take responsibility for their own decision-making, preferring to place themselves in

[21] This particular doctor was a locum, covering for the weekend (explained by Ellen)

the hands of experts, a position proposed by Kennedy – himself a doctor - (1983), which he felt was encouraged by a medical profession who had their own agenda of hospital-based, technology-focused care. The position, however, is not quite so simplistic. Women are encouraged to accept responsibility for their own health and that of their baby, working in partnership with health professionals and making decisions based on informed choice (WAG, 2006a), an idea recently adopted by health professionals. In maternity care, the notion of informed choice (see section 2.5) implies that women want to make their own decisions about care, and are given unbiased and complete information that will enable them to do so. In section 2.5, however, it was found that the way women learn and use knowledge differs, and sometimes they are given information of dubious quality so making an informed decision about care may not be as straightforward as it may first seem.

Reflexive modernity (Beck, 1992) encompasses the belief that new systems need to develop within society to absorb the era of technological advances that are constantly arising. This will necessitate a reasoned approach to science that will cross professional and political boundaries in a way that has not previously been carried out. This point is illustrated by Giddens (1995), who discusses how reproductive technologies in health care have affected society by removing the sociological need for marriage in Western society. There has been an unintentional effect on the requirement for a stable (marital) relationship, or even sexual relationship in order for a woman to become pregnant.
This means that the way in which medical information is imparted is worth consideration. It is often an unequal and one-way process, concentrating on the medical, rather than sociological or other aspects. In this 'discussion', the patient is unable to contribute her own thoughts and opinions (Lee and Garvin, 2003). Other factors may also play a part: the influences of social class have been found to affect how women participate in decision-making, suggesting that women are not the 'passive victims' of technology, implicitly assumed in the medicalisation of childbirth, but are collaborators in their care for their own reasons (Riessman, 1992),

There is a view, however, that medical knowledge is now becoming increasingly fragmented, as technological innovation gives rise to new specialist roles, described by Williams and Calnan, (1996 : ix) as a "*transformation of the traditional biomedical paradigm*." However, Williams and Calnan (1996) speculate that people are not always passive and accepting of medical care. Instead, they may wish to take a more active part in their healthcare. Here, the sociological notion of Giddens' (1991) idea of a reflexive consumer is transformed into that of a 'reflexive patient'.

In healthcare, a system of 'shared decision-making' between doctor / nurse and patient has been gaining momentum. Shared decision-making (SDM) is defined by Barratt (2008 : 408), as "*A move towards seeing the patient as having a central role in decision making about their own clinical care."* A study carried out by Edwards *et al* (2001) sought the views of potential healthcare users during a series of focus groups carried out in Wales and England during 1998 to 1999. Participants were asked their views on consumer involvement in shared decision making, after listening to a recorded consultation where the risks and benefits of hormone replacement therapy were outlined. Generally, support for the idea of SDM was found amongst participants, and many expressed their desire for this to happen, though their experiences showed that this did not often take place. There was an aspiration to reach an agreed decision with health professionals, but the desired outcomes for consumers did not always equate to those of health workers. As examples, it was discussed how consumers wanted to feel respected, and that they were able to make meaningful contributions to any decisions that were made. The findings were similar to those reported in earlier studies, for example Fitzpatrick *et al*, (1998), although they differed in other aspects, such as the perception of risk. Calculating risk is an area where people's choices vary, with some wishing to balance their preferences against available evidence, whilst others may wish to use analytical tools developed to aid such decisions (Barratt, 2008). In a study of 32 women that examined the relationship between empowerment and information in relation to Hormone Replacement, it was found that not all patients wanted to find out information or take responsibility for deciding their treatment (Henwood *et al*, 2003).

Barriers to implementing SDM have been identified by Legare *et al,* (2008), who found that health professionals cite time constraints, patient characteristics or the clinical situation as the main issues that affect the use of SDM in clinical practice. Lack of clarity in defining SDM has also been suggested by Charavel et al (2001), who feel that further research is needed to explore and identify ambiguities in the models on offer, before protocols to include SDM routinely in patient care can be developed. Parallels can be drawn between SDM and the notion of women being partners in their own care, proposed by the *'Changing Childbirth'* report (DoH, 1993). Although SDM takes place, with women being offered information and choices, this is not always possible in some emergency situations. Here, it is expected that the professional will take the lead, advising or guiding the individual to follow a particular path of care (Edwards *et al,* 2001). Ellen's views of the need to carry out a forceps delivery supported this stance, and reflected the trust and authority given to professionals to make decisions on the woman's behalf, found by Bluff and Holloway (1994).

However, concerns other than those associated with informed choice arose from women's experiences following transfer to the DGH. These related to the attitudes of two particular doctors, rather than to aspects of decision-making. A study by Reime *et al* (2004) demonstrated how different maternity carers held different attitudes towards birth. Obstetricians were found to have a predisposition towards technology and intervention, whilst midwives held the opposite view. Both Penny and Ellen attributed the doctor's attitudes to one of gender, with both women anticipating that a female obstetrician would have been more sympathetic. Penny had a male obstetrician and was of the opinion that being a man made him unsympathetic to her situation, whilst Ellen had a female obstetrician, and was shocked by her uncaring manner.

Recent research has shown that women choose their obstetrician for reasons other than gender: reputation and qualifications being two important influences (Johnson *et al*, 2005). The women in this study, however, had no choice. They were seen by the duty obstetrician, and whilst midwives were generally found to be supportive and helpful throughout the birth, the obstetric care that Penny and

Ellen received left them feeling that they had not been treated by the doctors in a caring and sympathetic manner.

These two situations demonstrate the mechanistic view of the human body associated with the medical mode of care, which has led to childbirth being viewed as a mechanical process (Bates, 2000). In addition, gender stereotyping with regard to illness is reportedly prevalent in the medical profession, with women seen to be more likely to suffer with emotional or psychosomatic disorders than men (Bernstein and Kane, 1981; Jordovana, 1989). Currently there is an increase in female doctors, and some studies have shown that women perceive a female doctor to be more empathic (Haar *et al*, 1975; Ivins and Kent, 1993); however, little difference was found in medical practices between male and female doctors by Arnold *et al* (1988). The use of gender stereotyping in medical textbooks and journals has been discussed by Ehrenreich and English, (2008), and Hunter, (2006), an issue noted almost twenty years earlier by Jordovana (1989). Feminist views of the medicalisation of childbirth focus on the subjugation of women by the (male) medical model of care, (see chapter four) but recognise that although some doctors are female, they are taught in a patriarchal system, therefore adopt the same attitudes as their male colleagues (Bilton *et al*, 2002). If medical education continues in this way, there seems to be little chance of a change in the underlying philosophies. This problem, however, has been recognised, and ways to encourage doctor / patient empathy which maintains the sense of the patient as a person are being explored by medical educationalists (Shapiro, 2008).

Professional boundaries are known to exist in various forms in healthcare. An obvious and well-documented area is the difference between obstetricians and midwives, with midwives seen as purveyors of normal birth, and obstetricians associated with technology, similar to that in nursing discussed by May and Fleming (1997). Although this can be traced back in history to professional rivalries between midwives and obstetricians, it has left a legacy of professional dissonance which can have a negative impact on the care of women (Kent, 2000). Technology continues to advance, and this has been equated with the impersonal and dehumanised care of people, in opposition to the 'hands-on'

approach adopted by nurses (Sandelowski, 1988). Technology, however, is not confined to the use of doctors: it is an inherent part of many aspects of nursing and midwifery care, and can help to determine when maternity care can continue under the care of a midwife, or be required to transfer to an obstetrician. A common example of this is the use of ultrasound scans to exclude the condition placenta praevia, discussed by Isobel in section 7.7.1. It is perhaps the underlying philosophies of care which mark the biggest differences between one health professional and another, and whether or not the care that is given is humane or impersonal (Barnard and Sandelowski, 2001). In the example above, Ellen's concerns were not with her lack of involvement in decision-making, or with the use of technology (obstetric forceps), but with the attitude of the doctor during and after the birth.

Ways of overcoming professional boundaries to improve health care for women have been under consideration for several years (Reiger and Lane, 2009; Winthereik, 2008; Barrett, 2006). Multidisciplinary working is now the byword in maternity and other health care, but in order for this to be effective, existing barriers need to be removed, requiring work from all involved. An environment of honesty, trust, mutual understanding and recognition needs to be fostered (Reiger and Lane, 2009; Stapleton, 1998; Keleher, 1998). This brings many advantages to patient care, including increased satisfaction, but perhaps the most dramatic is that recognized by the International Confederation of Midwives, who cite this as the best way of reducing maternal death from post-partum haemorrhage in low-resource countries worldwide (ICM, 2006). In this study, collaborative and multidisciplinary working was seen in the way that transfers of care were arranged and carried out, and in the case of Alison, continued to offer her the chance to try and achieve a normal birth. Unfortunately, this did not appear to be the case for Penny and Ellen. Although the midwives were prepared to advise that the locum doctor should not return to work within the unit, the midwives could have acted more assertively when the doctor's attitudes and actions were so distressing to the women. It is not known if the midwives spoke with the doctors outside the room, but they should have been prepared to act as the woman's advocate at the time. A Confidential Enquiry into Maternal Deaths (RCOG, 2002) stressed the importance of midwives being able to challenge

medical and other staff, where they do not agree with aspects of the care[22]. Although the midwives were supportive in other ways, they colluded with the care being given in this instance.

Although there were examples of woman-centred care given by doctors and midwives that acted as a counterbalance, this theme contained some challenging and upsetting views of care experienced by women. The contrast between different philosophical approaches was made most evident in these stories, and related in some instances to women feeling that they were not being treated as a person. Women thought that female doctors would be more empathic and caring, but this was not found to be the case, as there was an instance of both a male and a female doctor subjecting women to a mechanistic and impersonal form of care. Midwives, whilst being held by the women as being supportive and helpful, failed to act as advocate for the women in some instances, demonstrating that the medical model continues to dominate care and remains unchallenged.

### 7.12 Theme Seven - Birth as a Family Event

Family members played an important part in pregnancy and when preparing for the birth. They might accompany the women, act as carers for other children, influence women's decisions about their care, or participate in plans to integrate the new baby into the family without existing children feeling marginalized.

Having the family present at birth and during the stay in the birth centre was one of the reasons for choosing care there. Penny wanted to share the event with all her family. Her parents and brother as well as her partner supported her in labour in the birth centre, and she had planned for them to stay with her as long as possible. This could not be accommodated in the DGH, however. Penny summed up her feelings after she was transferred:

> *"When you've had the baby and gone to the wards, you're like on your own…they sent my family home…I just wanted to sleep but I couldn't anyway, and I just wanted someone there with me."* *PENNY*

[22] This was associated with plans of care, but the principle remains the same.

Penny was describing the feeling of exhilaration, which follows giving birth, when, tired though you may be, you want to share the experience with your family, taking time to marvel at the baby. Penny insisted on returning to the birth centre a few hours after the birth, where she was able to do this:

*"Back in the birth centre, I was so joyful, I wanted to share it with everybody. It was easy there, we could all be together and watch what the baby was doing and that."*
*PENNY*

Alison, able to have her family present during labour, was not so lucky postnatally. The birth centre was full, so she could not return for postnatal care. The DGH imposed a stricter visiting regime, with a limit to the amount of visitors that could be present at one time. She describes her experience, in contrast to that of Penny:

*"Cos my mum and dad were down and my brother, he (her husband) had to give up his visiting times for all these people, so he only got to see us, his shift was between four and six at night, so…that was a long day."* *ALISON*

This social aspect of sharing the birth however, does not automatically confer personal support for the woman during labour. Women's needs differ, some women retreating into themselves during labour and not wanting distraction, others finding details like brow mopping and back rubbing essential to get them through the experience. The midwife gives help and support to the labouring woman, but has a professional role. What is important for women is that someone is there just for them – to do whatever is needed, and to give unconditional support.

Sarah found herself in an unusual position, as the issue of support posed a problem. Her own wishes had to be weighed against those of her husband:

*"Paul had said that he was relieved that I was going to the DGH, he hadn't really let on, but he hadn't felt comfortable…it was the old fashioned thing of there being no doctor, 'what if something goes wrong?'…So we talked about it and I could see that he wasn't happy and relaxed about it, so I think we both had to be happy, so we decided to stay with (DGH)."* *SARAH*

By choosing to go along with her husband, Sarah had assured herself of his help and support in labour when she most needed it, and this took precedence over other needs. She could not, as she disclosed later, even rely on the support of her

mother or other family members, as they shared her husband's fears. Although Sarah had seemed surprisingly acquiescent in her decision, there may have been more complex undercurrents, which had been explored before arriving at the decision.

Sarah still liked the birth centre concept, was sad that she would no longer be seeing her named midwife, whom she felt was *"like a friend, but not over familiar either"*, but had her husband's feelings to consider if she was to undertake another pregnancy:

> *"I would like to think that I could go to the birth centre, but it would have to be a family decision."*

Sarah went on to explain:

> *"I'd be sad if I didn't have the experience of midwifery led care. I mean, he could see what wonderful care I was having at the birth centre, but he's got this old fashioned attitude about what if? I've had two really easy births, so perhaps that would inspire him a bit."* *SARAH*

What Sarah described as an 'old fashioned[23]' attitude remains commonplace.

### 7.12.1 Discussion

In developed cultures, it is unusual for a woman to give birth without a friend or relative present to give support. More often than not, this is the partner or husband; what was once seen as women's business has taken on a new social meaning. The image of the husband pacing about outside the birthing room has been replaced by the expectation that the woman's partner (in most instances the baby's father) will be present to share the moment of the child's birth, and increasingly, family members and friends are invited to be there as well. The birth centre offered the choice for unrestricted visiting which was seen to be an important aspect by many women in this study. Problems arose following transfer, however, as the DGH had a different visiting policy, as the women's responses indicated.

[23] By 'old fashioned', Sarah was referring to the belief that hospital based care (in the DGH) was equated to quality care, and that by opting to have the baby in the birth centre, they were somehow choosing a second rate and more risky service.

Sarah's situation was somewhat different from the other women: her husband and family were supportive, but the support was not unconditional. It was instead based on Sarah complying with their wishes for her to give birth in the DGH, rather than her own choice of the birth centre. As Sarah had had a previous normal and easy birth (her own opinion), this did not seem a logical decision. Although Sarah explained this as being an '*old fashioned*' attitude, it would have been interesting to explore this issue further, to establish the reasons for this. Possible causes for this were perhaps those proposed by Raphael-Leff (2001), who describes how some men can be subject to feelings of vulnerability during pregnancy when linked with certain life-events, and Vernon (2006), who discusses how men can feel afraid of the complications which surround birth, feeling unable to exert control over events.

A factor that may have influenced Sarah's choice was described by Levy (1999), as the result of a grounded theory study involving 12 women from the East Midlands. She found that there was one over-riding element that influenced how women made choices for their care; this was described as *'maintaining equilibrium'*. The woman made her choices to balance and protect her family life, choosing to ignore or disregard information that might upset her family situation.

The notion of 'family' has evolved over time, and families differ between societies, so there are many definitions of family (Haralambos and Holborn, 1991; Abbott and Wallace, 1997). In the UK, a stereotypical family image is that of the nuclear family – mother, father and children living together, the sort of family which people living in industrialised, westernised societies aspire to today (Giddens, 1997). There are, however, many other types of family present in the UK. Some examples include extended families, characterised by several generations of family living together or in close proximity or contact; single or lone parent families which result from death, divorce, separation or choice; step families, which include children from previous marriages or relationships; symmetrical families, an adjunct to the nuclear family, where both partners share some of the household functions and chores (Young and Wilmott, 1973).

Family functions, however families are characterised, share some common purposes within society that are associated with the order and continuation of societal life. Regional diversity within the UK has also been noted by sociologists, with areas of long-term industrial decline being characterised by conventional family structures. The valley of Cwm Fechan fulfils the description given by Eversley and Bonnerjea, (1982), as it was founded on heavy industry and had been a strongly patriarchal with robust family and neighbourhood connections.

The women interviewed postnatally, however, did not all originate from the valley, and came from several different family structures: Lynne and Penny originated from the valley, whilst Alison, Rachel and Ellen had recently moved into the area. Alison, Ellen, Lynn and Rachel were in relationships that might be considered a symmetrical family: they were co-habiting with partners or married and were in paid employment. Husbands or partners were expected to share childcare. Penny was a lone-parent, but from an extended family, living in close proximity to other family members, with whom she held a close relationship. For Alison and Penny, the extended family were invited to attend the birth, and provided support, together with their partners (though Penny separated from her partner in the postnatal period). For these two women, the importance of the family in being present at the birth was tied to their own socially constructed ideas of family. Both women came from different backgrounds and lived in different circumstances, but for both, the extended family was all-important.

For Penny, they were part of her daily life, and would be an important part of her baby's life, participating in childcare, and passing on their cultural influences as the baby developed. Alison lived away from her extended family, though they retained close ties, so having them present at the birth was a way of initiating the closeness and ensuring that it continued.

Family was an important consideration for the women in making their choices for the birth centre, with the extended family a consideration for some. The women received support from their families, but this support was sometimes conditional on the woman following her family's wishes, instead of her own.

The types of family described by the women differed, as did their social circumstances. This was in-keeping with the background of social constructionism discussed in chapter three. Sociological views of the family show how the nuclear family (married parents living together with children) continues to predominate in the UK, though there is a move towards other types of family, as was seen in this study. The construction of the family was shown to be changing within Cwm Fechan, moving away from a patriarchal society of nuclear families to one where women take on a more equal role with their partners.

### 7. 13 Birth, Parturition, Delivery or Confinement? The Social Construction of Childbirth.

There are many words commonly used to describe the process of childbirth. The word *birth* originates from Middle English, *parturition* derives from Latin. Both are associated with the production or bringing forth of offspring. *Confinement* is a word emerging in the 18th century as: *The being in childbed; delivery, accouchement' but* also *'the action of confining; being confined; imprisonment; restriction; limitation.* The word *delivery* has an earlier origin, being used to describe childbirth in the 16th century (associated with '*the action of setting free, release, rescue*')[24]. Words are not purely descriptive, however, but form the powerful medium of communication, with value and meaning conveyed according to who is talking and who is listening (Keller, 1980). The language surrounding birth therefore, is based on the assumptions made by the people involved, as Bruner (1990: 18) states: *"The meaning of talk is powerfully determined by the train of action in which it occurs."*

An example of this is seen in the word 'confinement'. Ferguson (1993) argued that this implied a woman who was confined to bed and restrictive routines, suggesting that the word birth should be substituted and this is now seen in more common usage, as for example in 'home birth', rather than 'home confinement'. Other authors have also discussed the language of birth, proposing that the dominant medical model of care has influenced the development of language

[24] All definitions from the Shorter Oxford English Dictionary Based on Historic Principles, 1973.

associated with childbirth, giving examples where common obstetric terminology such as '*cervical incompetence*[25]*'* or '*failure to progress*[26]' reduces women's status to passive, submissive, invisible and disempowered (Hunter, 2006). Kitzinger (2005) also describes how mechanistic language concentrates on childbirth as a mechanical process, with the woman being treated as part of the production line process. She cites the example of '*the mechanism of labour*', a well-known phrase used to describe the physiological process of birth. The opposite position, showing how a woman centred service using positive language during childbirth could empower women, acting as a positive influence for parenting was discussed by Page (1995).

Language reflects social constructionism, providing us with ways of giving meaning to our lives (Burr, 2003). Cosgrove (2007: 252) suggests that:

> *"It should by now be apparent that a social constructionist perspective maintains that any understanding we have of our experience, including our experience of gender, is mediated through language and is never independent of language; as such, it is socially produced."*

When looking at the medical model of care, the mechanistic language demonstrates the stance used by those working within the paradigm. This use of language, therefore, can be seen as a metaphor for the social constructions of childbirth; the women-centredness of the midwifery model of care contrasting with the mechanistic approach seen in the medical model. Throughout this study, these viewpoints have been demonstrated, with the addition of the views and actions of women. Each group has been shown to have their own perspective and agenda. Women want to be treated and respected as individuals; midwives want to concentrate on normality, and doctors pursue a mechanistic approach. Of course, the reality is not quite as simplistic, but the statement is intended to convey the different approaches to childbirth that have been demonstrated in this study. Socially constructed views of the world include shared beliefs and values, and precipitate certain actions, as Burr (2003: 5) states:

[25] Cervical incompetence is associated with late miscarriage, the cervix being unable to support a developing pregnancy after the first trimester.

[26] Where the progress of established labour slows or stops.

*"Our constructions of the world are therefore bound up with power relations because they have implication for what it is permissible for different people to do, and for how they treat others."*

These can be seen in the contrast between a mechanistic model of care and one that is women-centred. Women, the other participants in this study, follow a different social constructionism, however. This is based on their background, culture, and the influences of their family. The women in this study were not an homogenous group. They came from different socio-economic and educational backgrounds, demonstrated by where they lived, their housing and their occupations. Each woman had her own socially constructed view of what her experience of birth would be. Although they all lived in Cwm Fechan, the one common factor was the desire to give birth in the birth centre. This gave the women shared expectations: to be treated as a person, to be able to choose their supporters for birth, to know their midwife and to be in control of what happened to them, in other words, to experience a sense of personal agency. For the five women who gave birth in the DGH, this was lost; decisions and actions were ultimately controlled by others. In Sarah's case, this was by her husband and family, Alison and Lynn were eventually absorbed into the medical model of care, and Ellen and Penny experienced the mechanistic approach of the medical model. This study has been about women, and has sought to understand the process of childbirth in certain circumstances from the views of women who experienced it. Doctors and midwives may need to consider their own socially constructed viewpoint and look critically at whether their views are in accord with the women for whom they provide care. A healthy mother and baby is everyone's ultimate goal, but the way in which this is achieved matters to women.

## Chapter Eight: Conclusions and Recommendations

This chapter begins by revisiting the rationale for the study, and how the study's aims were developed to include issues that arose out of the preliminary literature review, in chapter two. The contribution of the study to the body of midwifery knowledge is discussed. Recommendations for practice and further research, based on the findings of the study are presented. Concluding remarks are offered, to give an insight into the way that the study has already been useful to inform local services, albeit in a small way.

The study was carried out in a birth centre, where midwifery-led care was provided to women with uncomplicated pregnancy. Unexpected problems sometimes arose that meant women had to be transferred to obstetric care in a different hospital. This process of transfer had led to some women being dissatisfied with their care. To begin with, the aim of the study was to explore the reasons for this dissatisfaction. However, further development and refinement of the project led to the final aims being:

- To identify why women chose midwifery-led care in a birth centre;
- To elicit women's expectations in the antenatal period and labour and to explore their experiences of care in the birth centre;
- To conduct an in-depth study of the experiences of women who had a transfer of care from the Birth Centre to the nearby obstetric unit in late pregnancy or during labour.

Examining the aims gave an overall picture of why women chose the birth centre, what they expected and experienced there, and finally, women's experiences of care when they were transferred to the care of an obstetrician in the DGH. The findings showed what these experiences of care meant to the women in this study, enabling recommendations for policy changes and practice to be suggested.

## 8.1 The Contribution of the Study

This study provides an original and informative contribution to what was known of women's experiences of transfer, and of the expectations and experiences of women from a socially deprived area in South Wales, when they chose to have midwifery-led care in a birth centre. There was little pre-existing research about women's experiences of transfer in the UK, or in countries where similar systems of care are provided by midwives. No studies had been undertaken about midwifery-led care in a location such as Cwm Fechan to elicit women's views and aspirations of childbirth.

The influence of social constructionism provided a different way of looking at women's experiences, as it considered social and cultural influences that might have been important to women in the locality. An understanding of women's backgrounds aided in the interpretation of information gathered during the research, and avoided stereotyping women. This was a danger when health carer's views of women were often based on an historical association with sickness, ill-health and the medical model of care. What was clearly demonstrated by this study was that the women shared common expectations and experiences with each other, regardless of their social differences, and these expectations and experiences were consistent with women from other studies discussed in the literature (See for example section 2.4).

The findings established many views of good and valued areas of practice, but other experiences clearly showed where changes could have been made. Giving firm recommendations to change practice is not possible from the findings of a small study such as this one, nevertheless, the findings provide a valuable insight to inform services, and support the findings from other, similar studies. Influencing practice in maternity care is within my remit as a midwifery manager, through participating in case reviews and benchmarking. Where professional rivalries and fragmented care once existed, a system of multidisciplinary, collaborative working is now in place. This means that all health professionals are required to work together to ensure best practice which meets the needs of women, thus improving their birth experiences.

## 8.2 Methodological Considerations

The use of phenomenology and thematic analysis to interpret the data achieved the objective of exploring women's experiences, thus meeting the aims of the study, though it is acknowledged that other, equally valid conclusions may have been drawn using other methods of research, or by a different researcher. Likewise, the study had limitations, and there could have been improvements in its design (see section 7.1). The existing study, however, achieved its aims. For a small group of women who chose birth centre care in Cwm Fechan, I had identified why this type of care was chosen, discovered their expectations and experiences during the antenatal period, and for a group of five women, explored their experiences when they were transferred to obstetric care in the DGH to give birth.

## 8.3 Recommendations for Practice

The following recommendations are mostly, though not exclusively, aimed at midwifery practice, supported by policy and research recommendations where they arise. They are not discussed in order of importance, but in the order in which they appeared during the course of the study.

### 8.3.1 Birth Plans

Birth plans were only made with regard to the birth centre, and although the midwives had discussed the possibility of transfer, they had not encouraged women to think beyond that occurrence. For some women, therefore, no clear plans for birth following transfer had been considered. Although it is not possible or even desirable to concentrate on negative aspects of childbirth, they are nevertheless likely to happen to some women. Part of making informed choices or decisions about care should extend to the period following transfer, to enable women to develop realistic expectations should this situation arise. The difficulty for women in articulating their wishes and desires once labour has started has been discussed on p 136. The midwife, therefore, is well placed to explain the woman's wishes to staff as care is handed over.

**Midwifery Practice**

- Information leaflets could explain about the possibility for transfer;

- Midwives should encourage women to think of plans for labour and birth, which include different outcomes;
- Midwives can act as a woman's advocate in making her wishes known to staff following transfer.

### 8.3.2 Future Plans for Birth

It is highly desirable that women have a full understanding of what happened during labour, particularly where emergencies occur which result in operative deliveries. This may have long-term effects on whether or not women choose to have other babies. The findings of the study supported the recommendations of NICE (2006). The midwife has an important role to fill in gaps in women's knowledge, but also to remind medical staff that they have a duty to ensure that the woman understood their actions.

**Unit Policy**

- The unit could carry out further research to see if the problem is more widespread;
- Guidelines offering women full explanations of events in labour, where emergency care or operative deliveries have occurred could be developed;
- This might be carried out by an obstetrician or senior midwife who is able to discuss implications for future pregnancy, and offered soon after birth, with the opportunity for further explanation if the woman wishes.

**Midwifery Practice**

- Midwives should ensure that their normal post-natal care includes a discussion with women, to give a full understanding of the events of birth.

**Medical Practice**

- Doctors should ensure that women are given full explanation about their care, including why medical procedures became necessary during labour and birth. The woman may wish her partner or family to be present at the discussion.

### 8.3.3 Mechanistic Care

Care within a medical model, in which a mechanistic approach was experienced by two women contrasted with the woman-centred approach experienced by others. Although the *Changing Childbirth Report* (DoH, 1993) is now 15 years old, woman centred care had not been encompassed by all practitioners associated with childbirth in this study. There have been recent changes in the education and training of doctors that seek to address such issues (see section 7.11.1), and the introduction of both multidisciplinary working, and collaborative care between health professionals means that care is more effective and more satisfying for women. Unfortunately, a minority of doctors displayed a mechanistic approach to care. In this study, midwives, also were found to be unable or unwilling to challenge unacceptable behaviour from doctors as it was happening, a situation which needs to be dealt with by empowering midwives to be able to question this approach, and establish ways of addressing its challenges. Today, multidisciplinary forums exist to discuss standards of care, recommended for example, through clinical governance, and labour ward forums. These include discussions of incidents and establish ways of dealing with unsatisfactory attitudes where a problem is observed. Midwives play a key role as an acknowledged advocate for the woman, and are therefore well-placed to identify a problem in attitudes and to act on it, and also to participate in the education of others to offer women centred care.

**Policy Change**

- A woman centred approach to care should be at the forefront of all policies relating to maternity services, an approach which is translated into action when dealing with women, rather than an empty gesture.

**Midwifery Practice**

- Midwives must identify and challenge behaviour which is inconsistent with woman-centred care, and follow clinical governance procedures to ensure the behaviour is dealt with appropriately;
- Midwives can participate in the education and training of others to promote woman centred care, and a system which values women as individuals;

- Midwives can be encouraged to move away from a medical model of care through midwifery supervision, training and education and through personal development plans.

**Medical Practice**

- In-service training could help doctors to move to a more woman-centred approach if necessary. This could accommodate issues of communication, particularly where medical emergencies arise.

### 8.3.4 Visiting: The Importance of Family Around the Time of Birth.

There was a difference in the visiting policies between the birth centre and DGH, understandable as space there was more limited, the unit was much busier and wards were shared between several mothers and babies. However, having family members other than husband or partner with them to celebrate the birth was an important factor for most women: something that was not always possible in the DGH. Some midwives were found to be more accommodating than others, particularly in the immediate period after birth. Meeting the women's needs was achievable with a little ingenuity and motivation on the part of the midwife.

**Unit Policy:**

- Ways to accommodate visitors that do not sacrifice the privacy and rest of other women in shared wards might be explored. This is particularly relevant in the period just following birth.

**Midwifery Practice:**

Midwives need to understand the role of the family and its importance to woman in their care on an individual basis. This should form part of their plan of care for women.

## 8.4 Recommendations for Further Research

The main recommendation arising from this study was a need for further research. This study was on a small scale, as were the other studies reviewed in the preliminary literature review, therefore the experiences of women transferred from midwifery to obstetric care have only been explored in relation to a few women. Although this information is valuable, it cannot be used to generalise all women's experiences of transfer.

Since undertaking this study, however, a wider scale research study has commenced, carried out by the National Perinatal Epidemiology Unit (NPEU), following a structured review of the outcomes for mothers and babies who planned to give birth in midwife-led birth centres in the UK (Stewart *et al,* 2004). As a result of this, the NPEU is in the process of conducting a nationwide survey within the UK (NPEU 2008 [Internet] http://www.npeu.ox.ac.uk/birthplace), which will encompass the experiences of women who are transferred. The study will be completed in 2009.

Other recommendations for further research also arose. These were:

- To explore the influences of family and partners on women's choices for care;
- To explore women's perceptions about the gender of their caregivers for maternity care;
- To establish why some midwives find difficulty in challenging unacceptable behaviour towards women by medical staff.

### 8.5 Concluding Remarks

As a midwifery manager, (and therefore as an employee of the NHS) an important aspect of the research was to be able to understand the views of women using the service. It was hoped that the study would be the catalyst to explore possible changes in practice. I am pleased to say that this study has already made a few small contributions. A new, purpose-built birth centre has recently been commissioned, and information about why women wanted to go to the birth centre, and the facilities they wanted to be provided there has proved to be informative throughout the programme of designing this new facility; what better asset than local, recent information about what women want from their birth centre? The recommendations for practice are also in progress, with some being easy to achieve, others less so. For example, the birth centre has recently begun a programme of mentorship for midwives to teach skills in assertiveness, and the study has been able to contribute towards discussions about developing guidelines for the discussion of operative and emergency deliveries with women in the postnatal period. Recommendations that are associated with attitudes,

however, are more difficult to address, and require a longer-term commitment to change.

There is scope for further research in the same area, with a larger or more in-depth study needed to explore some of the issues that arose in this and similar studies in more detail. As midwifery-led birth centres are now present in the majority of Trusts in Wales, perhaps this will provide a focus for such research. I feel it is more accurate to describe the end of this study as more of a beginning: for an improved service for women that is grounded in research and not based on supposition.

## Chapter Nine: Personal Reflections on the Study

I often reflect on professional matters, thinking how I could have done something better, or considering how something I have done well can be related to other things. I don't normally subscribe to public reflection on matters which are personal, however, as this study has been. Throughout the course of this study, I have considered myself to be on a journey, a voyage of discovery almost. This journey has begun with myself: my own experiences of childbirth, my expectations from a personal preference, to an anticipation of normality based on my mother's experience of four normal births, three of which were at home. I suppose it's been a bit of a catharsis, even though I've come to terms with me.

I began thinking of carrying out this research after speaking to a woman who was upset as her daughter was transferred in labour from birth centre to DGH. I was unable to determine if this was due to a specific problem, or was a more general feeling. Generally, women from the birth centre did not like being transferred, and any grumbles about care were put down to the birth environment being so different in the DGH to that in the birth centre, but we just did not know. The daughter did not want to complain, so it was left to her mum. I found myself wondering what the real issue was here – was it the difference in environment, or had the daughter's care not been up to scratch? Was the physical transfer frightening, or did she not have enough information about it? Was she never informed of the possibility in the first place? Was it the old issue of the different hospital in a different valley, reflecting long-held rivalries between the areas? Was it even the mum who was upset, rather than the daughter? I wondered, why did women want to go the birth centre? It was a question we had never dared ask when setting it up, afraid that women would just say it was closer, or visiting was easier, without understanding the whole concept of midwifery-led care – stereotyping again! The opportunity to carry out the research came with the introduction of the clinical governance agenda, risk management and the Welsh Risk Pool (The Welsh equivalent of CNST). Here was a chance to demonstrate that we were proactive in managing complaints, and a chance to get funding to do the research! I embarked on the project.

I know, because I have lived there for many years, that the history of the valley and the people there were inextricably linked, and this seemed to be important to the study. Understanding the growth and development of the valley helped to make sense of many things that are noticeable about the South Wales Valleys. The geography, how industry has left its mark, the pattern of urbanisation - a ribbon-type of development. I came across social constructionism during my research, and this provided a means to answer to many of my questions, especially how different areas of the valley show different attitudes to life. Social constructionism is a difficult concept, but it gave me the tools to look at women's experiences with a different eye, trying to understand their motivations and values, rather than imbue them with my own. This aspect has been one of the most valuable, as I was unaware of how pervasive the influence of the medical model of care is, even when we provide the midwifery model of care. Reading feminist criticisms of the medical model has been a revelation, again, something that I just did not see before. I cannot believe that I did not perceive the androcentric language and attitude that fills the NHS.

Choosing the method was difficult. I knew I wanted to use phenomenology, but the idea of using grounded theory niggled away at me. I was afraid that my own experience would provide too much of a bias, and I could not see how I could possibly bracket it all away. Attending a research module as part of the PhD process was useful – from this, I learned more about phenomenology. This was both a revelation and a relief. Gadamerian phenomenology embraced personal experience and made use of it, so avoided the issue of bracketing.

I enjoyed doing the interviews, even though I could have done them better. It's hard to appear dispassionate when you are appalled by what is being said to you about the way women have been treated. I was an inexperienced interviewer at the start, but improved along the way. I feel more experience would have allowed me to follow up on some of the things women said, enriching the study further. Interviews also proved frustrating: when women had gone out at our pre-arranged time, or kept avoiding meeting me, instead of saying they no-longer wanted to participate.

One of the hardest things, and one I have had to consciously fight all the way, was to keep midwives out of the study. The study was about women, and their experiences, not midwives. Midwifery keeps trying to get in there. For example, I found myself reading up on the effects of providing continuity of care on midwives, both good and bad, then realised that how we provide it didn't matter to the women, only that we did. I have done my best to keep it out, or at least keep it to a minimum.

An additional aspect for reflexivity was to consider my role as a midwife manager, when carrying out midwifery research. It was not known at the commencement of the study whether the initial complaints about care that acted as the catalyst for research occurred frequently, or were particular to those individual women. From a midwife manager's perspective, it was initially hoped that this research study would uncover the reasons behind, and offer solutions to those aspects of discontent with the service. This was later felt to be a naïve aspiration, and as the study progressed it became apparent that this would not be feasible. The study would of necessity be small-scale, and therefore would be able to contribute towards what was known of women's experiences of care, but not to give definitive advice about changing aspects of care.

Having been a midwife for a number of years, I had observed and heard about many different experiences of care. Even so, some of the experiences related by the women in this study still had the power to shock. The emotion with which the women related their stories was intense, and though I believed I was able to remain impassive during the interviews, their stories provoked reactions such as dismay (that these situations could arise), outrage (on their behalf) and defensiveness (that care had fallen short of what I would have expected). After each interview, whilst completing my field notes, I made a conscious effort to identify and record my own feelings and impressions, both positive and negative, so that these could be acknowledged prior to carrying out data analysis (an example of a field note is shown in appendix 13.)

Hearing about undesirable aspects of care was a difficult part of the interview for me, and the reaction as midwife manager to want to investigate these episodes

further had to be resisted. In these instances, I was given information as midwife researcher, not as midwife manager dealing with a complaint (in fact the women were unaware that I was a manager). I had to respect the women's confidences, and trust that they would. Working full-time in a responsible job makes the level of commitment needed to complete a PhD difficult. Although study leave was granted, and was initially quite generous, it has gradually diminished. Changing demands of my job have correspondingly increased, and I have felt that I was juggling at times. In retrospect, I underestimated how much work was involved, especially towards the end. I'm sorry that I was not able to do a full-time PhD – what a luxury to be able to spend hours in the library! Being a part-time student means it is difficult to be involved in university life, (even if I wanted to), although I have attended various workshops and lectures over the years. The five and then six years have gone so quickly. I can hardly believe that I enrolled in November 2002.

I realise this all sounds very negative – all the hardships and difficulties. Really, it has been a process of enlightenment. I have had a wonderful opportunity to pursue a personal and professional goal. I have found the literature tremendously interesting, so much so that it has been difficult to stick to the subject in hand. I have read obscure books and articles that I never would have dreamed existed.

So now my journey is almost over. Has it been worth it I ask myself? Well, I have to admit, even though it's been a lengthy process, I've learnt a lot of valuable information which I did not know before, and a bit that no-one else knew either.

## Glossary

| | |
|---|---|
| **Ante-partum Haemorrhage (APH)** | Bleeding from the genital tract after 24 weeks of pregnancy |
| **Birth Centre (MLU) can be:**<br>• **stand alone**<br>• **alongside**<br>• **integrated** | A unit which favours a homely environment, and concentrates on the care for normal pregnancy<br>• Separate unit from the DGH<br>• Adjacent to DGH obstetric unit<br>• Situated within the DGH maternity unit |
| **Cardiotocograph** | A machine that detects, measures and records the fetal heart, and maternal contractions |
| **'Co-op' Cards** | A form of hand-held record, now obsolete |
| **Instrumental Delivery** | Birth where either forceps or ventouse are required to help deliver the baby |
| **Membrane Sweep** | A vaginal examination carried out to try and stimulate labour |
| **Midwifery-led Care** | Maternity care where the midwife is the lead professional for providing and organising care for normal pregnancy |
| **Multiparous** | A woman who has one or more living children |
| **Nulliparous** | A woman with no living children, but may have had pregnancies |
| **Obstetric-led Care** | Maternity care where the woman has complex pregnancy needs, and requires a specialist medical doctor |
| **Pethidine** | Intramuscular analgesia used during labour |
| **Primiparous** | A woman in her first pregnancy |
| **Trimester** | A three-month period of pregnancy |

**Appendix 1**

DRAFT GUIDELINES FOR SELECTION OF WOMEN FOR DELIVERY IN CWM FECHAN BIRTH CENTRE. MAY, 1995

Women with any of the following risk factors should be encouraged to deliver in the DGH:

**1. Significant pre-existing medical disorders including:**

a. History of gynaecological surgery; cone biopsy, myomectomy, hysterectomy, fistula repair of perineum, surgery for incontinence
b. Renal disease, recurrent UTI
c. Pulmonary embolism, DVT
d. Diabetes Mellitus
e. Epilepsy
f. Hypertension
g. Cardiac disease
h. Thyrotoxicosis
i. Anaemia
j. Haemoglobinopathies
k. Tuberculosis
l. Drug abuse
m. Alcoholism
n. Obesity – greater than 90 kg
o. Previous anaesthetic problems

**2. Previous Obstetric History**

a. Recurrent miscarriage
b. Infertility
c. Operative delivery, LSCS, Forceps or Ventouse (other than lift-out)
d. Perinatal death or significant morbidity
e. Third stage problems; post-partum haemorrhage; inverted uterus; retained placenta
f. Isoimmunisation
g. Shoulder Dystocia

h. Previous delivery of baby weighing more than 4.5 kg
i. Abruption
j. Previous small-for-dates infant
k. Maternal indications
l. Height less than 5’ 0”
m. Age less than 16 or over 35 if primigravida
n. Multigravida over 40 years
o. Parity four or more previous pregnancies
p. Infections – HIV, Hepatitis B, Herpes Genitalis
q. Hydatidiform Mole
r. Prolonged active labour (primigravida – 12 hours, multigravida - 8 hrs)
s. Precipitate labour – 2 ½ hrs or less
t. Previous fetal malformation
u. Previous low APGAR score

**3. Reasons for Referral During Current Pregnancy**

a. Threatened abortion
b. Hypertension / Pre-Eclampsia
c. Intra-uterine Growth Retardation
d. Anaemia – less than 10g/dcl after 28 weeks
e. High-head at term
f. Poly / oligo hydramnios
g. Antepartum Haemorrhage
h. Multiple pregnancy
i. Premature rupture of membranes
j. Premature onset of labour – less than 37 weeks
k. Breech / oblique / transverse lie at 36 weeks gestation
l. Isoimmunisation

## Appendix 2

## Birth Centre Statistics, 1995 - 2005

| | 2005 | 2004 | 2003 | 2002 | 2001 | 2000 | 1999 | 1998 | 1997 | 1996 | 1995 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Bookings** | **320** | **261** | **282** | **275** | **271** | **261** | **254** | **257** | **242** | **220** | **21** |
| | | | | | | | | | | | |
| **Births** | **176** | **146** | **157** | **135** | **152** | **165** | **148** | **165** | **150** | **134** | **15** |
| **Primigravidae** | 63 | 52 | 63 | 33 | 47 | 44 | 45 | 44 | 43 | 34 | 4 |
| **Multigravidae** | 113 | 94 | 94 | 102 | 105 | 121 | 103 | 121 | 107 | 100 | 11 |
| | | | | | | | | | | | |
| **TENS** | 1 | 0 | 1 | 5 | 1 | 11 | 2 | 0 | 1 | 1 | 0 |
| **Entonox** | 72 | 58 | 70 | 44 | 59 | 63 | 62 | 82 | 64 | 61 | 14 |
| **Pethidine** | 73 | 75 | 66 | 56 | 66 | 71 | 58 | 62 | 60 | 39 | 8 |
| | | | | | | | | | | | |
| **Episiotomies** | 0 | 2 | 0 | 2 | 3 | 5 | 3 | 4 | 1 | 3 | 0 |
| **Intact Perinea** | 117 | 101 | 99 | 102 | 103 | 130 | 106 | 90 | 86 | 82 | 12 |
| **$3^{rd}$/ $4^{th}$ $^{o}$ Tear** | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | | | | | | | | | | |
| **Waterbirths** | 36 | 5* | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Pool in labour** | 76 | 23 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | | | | | | | | | | |
| **PPH** | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 2 | 0 |
| **Low APGAR** | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 |
| **Retained placenta** | 5 | 1 | 3 | 0 | 1 | 0 | 3 | 2 | 0 | 2 | 0 |
| | | | | | | | | | | | |
| **TRANSFERS** | | | | | | | | | | | |
| **In labour** | 39 | 15 | 14 | 12 | 27 | 29 | 17 | 15 | 18 | 21 | 0 |
| **Antenatal** | 103 | 29 | 32 | 23 | 29 | 16 | 37 | 24 | 31 | 38 | 0 |
| **Postnatal** | 6 | 2 | 3 | 3 | 2 | 2 | 4 | 4 | 2 | 2 | 0 |
| **Neonatal** | 1 | 1 | 0 | 1 | 3 | 1 | 2 | 0 | 0 | 1 | 0 |
| | | | | | | | | | | | |

* pool installed late 2004

**Appendix 3**

**The NPNR Journal Club's Approach to Critique**
(adapted from Cutcliffe and Ward, 2003)

## Guidelines

- Follow the sequence of the paper as laid out by the author
- consider each of the dimensions for each of the headed sections laid out
    - theoretical
    - substantive
    - methodological
    - ethical
    - presentational
- ask methodological questions in keeping with the paradigm used by the author – application may not be possible in qualitative research
- use existing critique approaches if helpful
- locate your questions in the wider literature for education / practice / research / policy etc
- reflect and identify how this piece of research helps you as midwife / clinician / manager etc
- reflect and identify the meaning of this research for the discipline
- identify 3 key points – at least 1 positive and 1 negative
- look for and highlight at least 1 strength of the paper
- give references to substantiate your critique
- look at the paper as a whole, not just in sections – highlight sections strengths and weaknesses

## Additional questions

- Is it understandable / accessible?
- Does it have the potential to inform / change practice?
- What are the key points from the study, and the key points for practice?
- Is the model accessible to all, or does it need higher education to understand?

**Appendix 4**

**CWM FECHAN MIDWIFE-LED UNIT PROJECT STEERING GROUP**

**Note of the fifth steering -group meeting held in Cwm Fechan Birth Centre on**

**11 April, 1995**

**Present:**

| | |
|---|---|
| **Chairperson** | **SE, Director of Nursing** |
| **Secretary** | **JF, Project Manager, VFM unit, Welsh Office** |

**Steering-group Members:**

**JD, Manager, Cwm Fechan Birth Centre**
**LE, Midwife, Cwm Fechan Birth Centre**
**ST, Head of Midwifery Services**
**AW, GP in Cwm Fechan**

1. Apologies for absence had been received from Mrs GB, midwifery advisor, Mrs SD and Dr JA, Welsh Office advisors, and Dr BS, Chair of Mid Glamorgan Health Authority.

2. **Minutes from the last meeting –** The amendments of the last item, paragraph 3 had been made. The membership of the steering group had been altered to reflect the position of Dr JA and Mrs SD as observers.

3. **Matters Arising –**

    a) GP Visits: it was reported that all but one of the remaining GPs had been visited and the last one was to be visited the following afternoon. As with the other GPs, there were no problems, and

the changes made to the protocols could stand, i.e. for requesting and receiving test results.

b) Building work in the Birth Centre: a further delay had been identified which would incur further expense but this would not cause a delay to the June 1st booking date.

c) Protocols: the amended protocols had been received. Since the last meeting the consultants had requested that all references to their offering advice regarding transfer of patients to consultant care be removed. Bearing this in mind, it was requested to remove paragraph 5 from the transport protocol as it now made no sense. A query was raised by Dr W as to whether the consultants could refuse to offer advice, and it was agreed that this would be investigated and reported back to the steering group. It was decided, however, that the protocols could stand as they were, without reference to the consultants offering advice to avoid delaying the ongoing launch work. It was reported by ST that new regulations had come into force regarding Vitamin K, and amendments needed to be made to the protocols. ST would advise the secretary so that the changes could be made.

d) The issue regarding GPs who did not provide neonatal ad postnatal examinations was to be discussed at a meeting with Dr BS to establish that a specified GP could perform them under contract.

4. **Viability of the Unit –** there was a general discussion regarding the viability of the unit and it was agreed that a suitable lead-in time would be required to establish whether the unit was viable. It was felt that this would be a matter for the Heath Authority to decide, but it appeared that Dr BS had acknowledged that putting a figure on the number of bookings at an early stage was difficult. It was agreed that this matter would be clarified at the forthcoming meeting with Dr BS.

5. **Launch of the Unit –** the secretary briefed the steering-group on the work carried out to date but requested that confirmation could be given

about the go-ahead for the launch because of the work involved and the timescale. It was agreed to confirm this after the meeting with Dr BS. The draft information leaflet was discussed and all present accepted the content as appropriate.

6. **There being no other business, the meeting was closed.**

**Appendix 5**

**Minutes of Birth Centre Steering Group Meeting, 1994**

**CWM FECHAN MIDWIFE-LED UNIT PROJECT STEERING GROUP**

*note of the second steering group meeting held in Cwm Fechan Birth Centre on 27 May, 1994*

**Present:**

| | |
|---|---|
| **Chairperson** | **SE, Director of Nursing** |
| **Secretary** | **JF, Project Manager, VFM Unit, Welsh Office** |

**Steering Group Members:**

| | |
|---|---|
| **Dr A** | **Medical Officer Consultant Advisor, Welsh Office** |
| **GB** | **Midwife Consultant** |
| **JD** | **Manager, Cwm Fechan Maternity Services** |
| **SD** | **Nursing Officer, Welsh Office** |
| **LE** | **Midwife, Cwm Fechan Maternity Services** |
| **Mr E** | **Clinical Director, Obstetrics and Gynaecology** |
| **Dr M** | **Clinical Director, Pathology** |
| **ST** | **Head of Midwifery** |
| **Dr W** | **GP, Cwm Fechan** |

**Also present:** **KR, Unit General Manager**

1. Apologies had been received from HE and Dr G (radiologist). KR and KM were welcomed to the meeting.

2. **Minutes from the last meeting –** It was requested that the last paragraph in section 3 be removed and that JA be included on the project board. This was agreed. The minutes were agreed as a true record of the meeting.

3. **Matters Arising** –

    a. JD reported on the delivery figures based on mother's residence. The figures demonstrated a fall in the number of deliveries in Cwm Fechan but there is a fall in numbers nationally. JA queried the reason for this fall. It was reported that the DGH had increased its activity and that the Cwm Fechan obstetric unit had been closed on occasion for operational reasons. JA asked whether the Cwm Fechan fall was also due to booking reductions.

It was reported that due to the better facilities at the DGH there was a tendency for women to book there first. AW confirmed that this was not necessarily the GPs decision.

b. Insert for paper two – (Project Board and Steering Group Role and Functions) It was requested that an amendment be made to remove the cost comparison exercise and evaluation of the Unit as part of the role of the Steering Group.

c. KM and Dr G had agreed to join the group as part of KR's invitation.

d. It was reported that the LMC had not responded formally but had informally agreed to AW being the representative for the LMC.

e. KM was asked his view on the project. He stated that his colleagues were opposed to the birth centre in Cwm Fechan but were in favour of a birth centre at the DGH. SD clarified the position for KM by explaining that the project was in response to Mid Glamorgan Health Authority's intentions that Cwm Fechan Unit should be developed into a birth centre and that in response to this the Welsh Office were assisting by giving advice on policy issues. She added that she was aware that the consultants had expressed their concerns to the CMO who had addressed their concerns in her reply.

f. KM stated that he would accept requests for tests from midwives but the results would be sent back to GPs. Dr G had stated to his colleagues that he would only accept requests for ultrasounds from GPs. After further discussion it was agreed to set up meetings with pathology and radiology to agree action on requests and results. The birth centre agreed to accept responsibility for results but that copies would go to GPs, as they would be asked to check up abnormal results as they do now with cytology screening. The end result should be that all women receive the same level of service as agreed Unit policy for the Health Unit. If there was less of a service provided the purchaser would need to be advised of this decision and the reasons for it.

g. **Progress from Sub-Groups** – It was noted that HE had co-operated and assisted with the production of the protocols and that his suggestions had been taken on board. The group made further suggestions for amendments. There was some concern that there could be problems with interpretation of some issues. It was agreed that an exercise would be undertaken using the new criteria for previous births to ascertain how many would have passed the booking criteria for midwifery-led care.

h. **A**reas for GP discussion and agreement had been identified and it was agreed to approach GPs to seek their views and co-operation.

It was also agreed that there was a need to clarify precisely the ambulance / paramedic cover that would be provided, i.e. that it need be formally agreed as part of the SLA.

i. The new working rota had been agreed by the midwifery team and was working well.

j. **Training** – GB reported that the programme had been completed and the notes were being produced

There being no further business, the meeting then closed.

**Appendix 6**

**Example of Coded Interview Transcript using NVivo**

DOCUMENT CODING REPORT

Document: Alison - labour transfer
Created: 07/09/2007 - 12:56:40
Modified: 22/12/2007 - 17:26:20
Description:

Alison labour transfer

Nodes in Set: All Nodes

**Node 1 of 20 choices**

Passage 1 of 1 Section 23.1, Para 150, 558 chars.

150: I felt that I had choices; they were asking do you want to do this or that. It was my choice to have my waters broken, and they asked if I wanted to get up and that, so the whole time it was very much my choice of what I wanted to do, and I think they tried, I mean obviously they knew I was from the birth centre, and I was trying to avoid taking anything, so they were checking with me what I wanted to do, and they let me go as long as I possibly could until the end when the specialist came in and said "nothings happening, and we need to go to theatre"

---

**Node 2 of 20 coming to terms with birth**

Passage 1 of 2 Section 12.1, Paras 75 to 76, 283 chars.

75: Yes, the ideal was a water birth, but I was totally prepared for the possibility of a section it happens, and my husband said...
76: I was getting later and later, and thinking she was getting bigger as I got later,

my stomach was getting bigger, we knew she was going to be big anyway

---

Passage 2 of 2 Section 22.1, Para 144, 451 chars.

144: but we did kind of say all the way through our pregnancy, oh we're going for this ultra natural water birth, and we were saying oh you'll have a sunroof! you'll be open like a can of sardines, but my friend in [names town[ she was the opposite, she was all for having an epidural, she was going to have a girl, and we kind of did a switch, she had natural childbirth, ended up with a boy and I had her C Section, so we had a bit of a laugh about that.

---

**Node 3 of 20 dealing with labour pain**

Passage 1 of 1 Section 19.1, Para 121, 783 chars.

121: I think I went through the whole night just on the TENS machine, and I think I was so totally concentrating I forgot there was any other kind of pain relief you know, and when I was waiting for the ambulance, it seemed like such a long time since they phoned the ambulance and they (contractions) were getting quite sore, they actually had to phone the ambulance and tell them to get a move on, and she said "do you want to try gas and air?", and it was brilliant, and the TENS machine, that was brilliant as it was something I was really concentrating on, and as my mum said, I was away with the fairies, I was having these big contractions and I was clicking away at the Tens machine, so I was perfectly OK with that, but the gas and air just seemed to take the edge off it, so ...

---

**Node 4 of 20 DGH midwives**

Passage 1 of 1 Section 14.1, Para 88, 133 chars.

88: I had a student midwife who was really nice, and the sister was the other one taking care of me, so they were both great, reassuring.

---

**Node 5 of 20 disappointment**

Passage 1 of 3 Section 7.1, Para 45, 356 chars.

45: Yeah, I wasn't disappointed, I think when they 'phoned the registrar, I expected to go straight in for a section, but they let me carry on labouring, y'know, give it my best shot, and if I'd gone in straight for a section I'd have been wondering if we could have done something else, so I was wasn't disappointed, in the end she just wasn't going to shift

---

Passage 2 of 3 Section 11.1, Para 69, 49 chars.

69: we gave it a go, so I wasn't disappointed really:

---

Passage 3 of 3 Section 17.1, Para 108, 450 chars.

108: He was a bit disappointed that he didn't get to cut the cord and nicey things he was looking forward to doing like that, and because it was so late in the day she was delivered at ¼ to 8, visitors were out by 9, so, the midwife was really nice, and they put us in the recovery room for a while, but I had to go the ward and he had to go home, so it was a bit of a shame like that, he was on a high and had to just go, but other than that he was fine.

---

**Node 6 of 20 doctors**

Passage 1 of 1 Section 23.1, Para 150, 82 chars.

150: the specialist came in and said "nothings happening, and we need to go to theatre"

---

**Node 7 of 20 family**

Passage 1 of 1 Section 15.1, Para 94, 542 chars.

94: that was a bit disappointing because my husband had taken a weeks holiday and was kind of sat round here, a bit of a spare part ‘cos he could only come at visiting times. We had expected, a couple of friends had had their babies in [names town], and fathers are allowed in that hospital all day so he was expecting to be allowed back and forth, and cos my mum and dad were down and my brother, he had to give up visiting times for all these people, so he only got to see us, his shift was between 4 and 6 at night, so... that was a long day.

---

**Node 8 of 20 husband ~ partner**

Passage 1 of 1 Section 17.1, Para 108, 450 chars.

108: He was a bit disappointed that he didn’t get to cut the cord and nicey things he was looking forward to doing like that, and because it was so late in the day she was delivered at ¼ to 8, visitors were out by 9, so, the midwife was really nice, and they put us in the recovery room for a while, but I had to go the ward and he had to go home, so it was a bit of a shame like that, he was on a high and had to just go, but other than that he was fine.

---

**Node 9 of 20 making decisions**

Passage 1 of 1 Section 8.1, Para 51, 98 chars.

51: he Birth centre was great, and the Hospital was great as well, it all was happy in the end, so...

---

**Node 10 of 20 reaction to need for transfer**

Passage 1 of 1 Section 18.1, Paras 114 to 115, 983 chars.

114: §36 Alison

115: Ummm, oh I think I knew. I think I knew when, I mean if I was 3cm on the Friday and then after labouring all day on the Sunday and having that exam at 3

in the morning and she said I was still 3, I thought well there's something going on, and then I was having such hard contractions when they examined me again at eight I thought I had to be at least 5, and they said I was still 3, and I thought its not happening, nothing's happening, so I'd kind of worked it out already, I knew myself that, at that point I knew I'd have a C Section, even though I carried on for the rest of the day, and they were like " are you alright for another hour, do you want to try another hour?", and I would say yes yes, try and give it a go, but... I did have a bit of an elation when I'd gone in (to PCH) and they'd examined me and I was 5, I thought maybe Its coming along, but I think when, yeah when they said that morning I was still 3, I thought Oh, C Section. That's the way it went.

---

**Node 11 of 20 returning to birth centre**

Passage 1 of 1 Section 16.1, Para 100, 203 chars.

100: so the nurse asked if I wanted to go to the birth centre which I said would be great, as I was expecting to stay in until Friday. She come back later and said I've some bad news, the birth centre is full to the brim,

---

**Node 12 of 20 telling the story**

Passage 1 of 3 Section 0, Paras 8 to 14, 3429 chars.

8: Oh, What happened! It started Sunday night, probably about 7 o'clock I started having contractions, so we'd had some in the afternoon but they hadn't come to anything, so about 7 o'clock they started coming quite regular, so we started writing them down, whatever, about half past nine they were definitely coming stronger, so I thought I'd try and get a nap, so I went to bed for a bit, and put the TENS machine on. I mean, I was fine, but my husband was like "lets go, lets go!" so about ½ past 2 we did go down. Now earlier that day I'd been down for a sweep 'cos I was late, so this was my second sweep, and (Midwife) said you're a bout 3 cm, so something is obviously happening, but you're not getting any real contractions or pains or anything yet, so obviously I'd been in labour

from about 7 to 3 o'clock, when she examined me, and I was still 3 cm, so she said "oh, get up and walk around", so I was fine, in the room, with the TENS machine on, on my feet the whole time, and when the next shift came on, when they changed over I was examined again, about 8 o'clock in the morning, and I was 3 cm again, and I'd been through really quite strong, frequent contractions, and she (midwife) said, really something should have been happening by now, so when she examined me again, she said that the baby was a bit high, so she would 'phone the registrar in DGH, and see what they wanted to do. So they phoned, and he said we'd have to go over to [names DGH]. By then the contractions were getting really quite sore, so they put me on gas and air, cos I had a good hour's wait for the ambulance to come and get me. It was the longest wait for anything, and that was fine, so I got to the hospital, and then they examined me about, well they put me on the monitor, she (baby) was fine, so they examined me and I was 5 cm, so by then we thought well maybe something is happening after all, so they said "keep on your feet as she's still high up, try and bring her down", so I was squatting and rocking and they kept me going to the toilet, a few hours later they checked me again and I was 8 cm, but she was still high up and in the end, it was about 7 o'clock that evening so It's been going about 24 hours, still only on gas and air and the TENS machine, I was coping with it fine, but she wasn't coming down, and I was 10 cm gone, but I had an anterior lip that wasn't shifting, so they got the specialist in and he said "baby's happy as Larry but not shifting down at all, she was still 3/5ths engaged. By then I was absolutely... I was fine but by then my contractions were coming back to back, it's just that I was absolutely exhausted, absolutely exhausted, so... I think I knew even before I left the Birth Centre: she hasn't dropped, I'm already late, you know, I kind of definitely thought I would end up a C Section, but everyone was like, "Oh, were you disappointed?" but I wasn't, you know, we did everything we could, we went through the whole thing, you know, I had my waters broken in the end which was something I didn't really want to do, but nothing was happening...
9:
10: §3 Liz
11: You try everything
12:
13: §4 Alison

14: Yeah, we thought give it a go, but no. They monitored the whole way through and she was not in any distress, just didn't want to come out, so she was 10 days late, so she didn't want to come out. When they pulled her out she had a face like thunder, the midwife's were laughing, she had a right sulk on
15:

---

Passage 2 of 3 Section 4.1, Para 26, 260 chars.

26: Yes, she had bruising across her shoulders they were trying to get me to push but I just didn't feel any pressure, it was all in the wrong place y'know... so that was that she's a big girl, but not really massive by any standards, she just didn't want to...

---

Passage 3 of 3 Section 5.1, Para 32, 97 chars.

32: Yeah, they were concerned that she was in the wrong position, facing the wrong way, back to back

---

**Node 13 of 20 type of birth**

Passage 1 of 1 Section 21.1, Para 138, 491 chars.

138: I don't know why I was expecting them to say "oh we're just going to make an incision now" or something like that, and before I knew it, I could hear her crying, I thought crikey, is that it, and then they said it was a girl and we were just so shocked cos everybody had expected it to be a boy, so it was a lovely surprise at the end of the day when they said it was a girl, all the old wives tales saying it would be a boy, so it was a little bonus when they said it was a girl at the end

---

**Appendix 7**

**Antenatal Interview guide**

Explain study

Explain tape and gain consent for use

Explain data protection – info and storage/ anonymity

Ask demographic details:

- family
- job
- ? mat leave
- education / training

Ask choice for birth centre

Expectations of care

Ask experiences of care

Problems?

Parentcraft

Plans for birth

Information about pregnancy etc

Ask if willing for PN interview

**Appendix 8**

**Woman's Letter of Explanation**

PATIENT INFORMATION

WOMEN'S EXPECTATIONS AND EXPERIENCES OF LABOUR AND BIRTH WHEN CHOOSING MIDWIFERY LED CARE IN A BIRTH CENTRE

You are invited to take part in the above research study. Before you decide, it is important that you understand why the study is being done and what it will involve. I would be very grateful if you will take the time to read the following information carefully and discuss it with your friends or relatives. Please ask if there is anything that is not clear, or if you would like more information. Take time to consider whether or not you wish to take part. If you do decide to take part in this study, you will be given a copy of the information sheet and a signed consent form to keep.

**What is the purpose of the study?**

I want to find out the reasons why women choose to book for care in the Birth Centre, and their experiences of labour and birth. In order to do this, I need to find out women's views before and after they have had their baby.

**Why have I been chosen?**

You have been chosen as you have booked for Midwifery Led Care (MLC) and to have your baby in the Birth Centre in a few weeks time.

**Do I have to take part?**

Participation in the study is entirely voluntary, and you may change your mind at any time, without having to give your reasons.

If you do not wish to take part, or wish to withdraw from the study at any time **this will not affect the standard of care you receive in any way.**

**What will happen to me if I take part?**

There will be an initial interview at around 38 weeks of pregnancy. Postnatally, I will either interview you again, or ask you to fill in a short questionnaire.

At the 38 week interview, I will be interested in finding out the reasons why you chose to book for care in the Birth Centre. The interview will probably take about 15 minutes, and could be carried out when attending for an antenatal check, at home, or in the Birth Centre, whichever is more convenient.

I will then be in contact after the birth, to find out your experiences of labour and birth. If I would like you to fill in a questionnaire, this will be given to you by your midwife when the baby is a week old. You can return it by post in the pre-paid envelope (or hand it back to your midwife if you prefer). If I would like to interview you, I will contact you when the baby is around 10 days old, and this could be carried out in the Birth Centre, or at home, whichever is more convenient.

I will need to make some notes, and I would also like to tape the interview (with your agreement), to make sure that I have an accurate record of all that was said. I will make a final visit to show you my summary of the interview, to ensure that it accurately reflects what you were feeling at that time.

When I have typed my notes, I will need to make a statement about all the things we discussed, and will need to contact you again to check that I have correctly interpreted your feelings at that time. (I will telephone you to make convenient arrangements)

**What are the possible benefits of taking part?**

Your views will help us to plan our services more effectively in the future, ensuring that we try and meet the needs of women in our local area.

**What are the disadvantages of taking part?**

For most women, birth is a positive and enjoyable experience, and one which they are keen to talk about. If your birth did not go as planned however, then you may not wish to discuss it with me – as mentioned previously, you can withdraw from the study at any time. Your midwife can help and advise if you are experiencing difficulties.

**Will my taking part in the study be kept confidential?**

All information which is collected about you during the course of the research will be kept strictly confidential, and any information about you which leaves the hospital will have your name and address removed so that you cannot be recognised from it.

With your permission, I will contact your GP if you agree to participate in this study.

**What will happen to the results of the research study?**

The research study is being undertaken for a PhD thesis, and may be published whole or in parts in professional midwifery or related health care journals. **You will not be identified in any reports or publications about the study.**

**Who has reviewed the study?**

This study has been reviewed independently by two members of NHS Trust's Research Risk Review Group and the South East Wales Local Research Ethics Committee in Cardiff.

If you would like to take part in the study, please tell your midwife. I will then contact you nearer to 38 weeks, to arrange the first interview. Thank you for taking the time to read the information about the study. If you would like further information, do not hesitate to contact me at the number given below.

Liz Edwards
Midwife researcher

## Appendix 9

## Request for Ethical Approval

Appendix 9 cannot be reproduced in this format.

If you want to review this appendix, please contact the researcher directly at:

liz.edwards@wales.nhs.uk

**Appendix 10**

**Participant Consent Form**

**PARTICIPANT CONSENT FORM**

WOMEN'S CHOICES, EXPECTATIONS AND EXPERIENCES OF WHEN INTENDING TO GIVE BIRTH IN A BIRTH CENTRE

The woman should complete the whole of this sheet herself (please circle one)

1. Have you read and understood the patient information sheet? Y /N
2. Have you had an opportunity to discuss this study and ask questions Y / N
3. Have you had a satisfactory answer to your questions? Y / N
4. Have you received enough information about the study? Y / N
5. Who has given you an explanation about the study?
   …….
6. Sections of your medical notes relating to your participation in this study may be inspected by responsible individuals from NG NHS Trust. All personal details will be treated as **STRICTLY CONFIDENTIAL**
7. Do you give permission for these individuals to access your notes? Y / N
8. Do you consent to informing your GP that you are taking part in the study? Y / N
9. Do you understand that you are free to withdraw from the study Y / N
   - At any time?
   - Without having to give a reason?
   - Without affecting your future medical care?
   - That details of your participation up to withdrawal from the study will be stored on file and may be used in the final analysis of data?
10. Have you had sufficient time to come to your decision? Y / N
11. Do you agree to participate in the study? Y / N

**PARTICIPANT CONSENT FORM**

WOMEN'S CHOICES, EXPECTATIONS AND EXPERIENCES OF WHEN INTENDING TO GIVE BIRTH IN A BIRTH CENTRE

PARTICIPANT

Signed……

Date……

Name (block letters)…….

_____

WITNESS

Signed……

Date……

Name (block letters)…….

_____

I have explained the study to the above participant and she has indicated her willingness to take part.

**INVESTIGATOR**

Signed……

Date……

Name (block letters)…….

_____

consent form 1
expectations and experiences of MLC
December 2003
Version 1

**Appendix 11**

**GP Information Letter**

Cwm Fechan Birth Centre

Dear Dr …….

Patient's Name…….
Hospital Number…….
Address ……

The above patient has kindly agreed to participate in a study identifying women's hopes and aspirations when choosing maternity care in a Midwife Led Birth Centre. I will be exploring the experiences of women who undergo transfer of care from the Birth Centre to the DGH in late pregnancy or labour by a programme of qualitative research.

I have provided the woman with the enclosed information sheet and my contact telephone number. If you would like further information about the study, please do not hesitate to contact me.

With kind regards,

Yours sincerely

Liz Edwards,
PhD student.

GP letter
Lived experience of women who are transferred from midwifery led care in a birth centre to obstetric care in a DGH
December 2003

**Appendix 12**

**Midwife Information Leaflet**

Dear

I am conducting a research study exploring the lived experiences of women who are transferred from their chosen type and place of care during late pregnancy or labour.

The main aims of the study are:

- To identify why women wanted midwifery-led care in a birth centre;
- To elicit women's expectations in the antenatal period and for labour and to explore their experiences of care;
- To conduct an in-depth study of the experiences of women who had a transfer of care from the Birth Centre to the nearby obstetric unit in late pregnancy or during labour.

I aim to recruit approximately 25 women into the study, all of who will be interviewed antenatally to establish the first aim of the study. Postnatally, I intend to interview five to ten women.

In order to carry out this study, I would be grateful for your assistance: -

I have an information leaflet that I will be sending out to women between 32 and 36 weeks. If any women express an interest in taking part when you carry out an antenatal check, please let me know - the leaflet asks women who are interested in participating in the study to let their midwife know. I will then contact them. I will only be selecting women over 38 weeks, to rule out as many antenatal transfers as possible.

Thank you for your support,

Liz Edwards
Midwife Researcher

**Appendix 13**

**Field notes, PN Interview, Penny.**

Marked difference from AN interview – seems more relaxed and confident (? because had met me before?) Happy to talk to me, even though drop-in visit.

Flat surprisingly bare, but had just split with boyfriend. All baby stuff in evidence.

Appeared open and honest – became upset and angry when talking about attitude of Dr. Otherwise, quite jokey about labour and birth. Made a comment about Dr being a man – wish I had followed this up.

Overall, experience positive throughout – complimentary about midwives.

**Personal Impressions of Interview**
**Surprise**

- much more self- assured than previous interview? why
- that she was still breastfeeding – obviously enjoying this aspect.

**Annoyance**

- birth experience marred by perception that Dr was insensitive
- also where was MW in this? – why wasn't she acting as Penny's advocate and intervening on her behalf?
- with myself for not following up cue about male doctor *( NOTE - ensure I make a written note of anything that needs follow-up in future interviews)*

**Shock**

- expected Dr to be sympathetic – unaware that this attitude could exist unchecked

**Appendix 14**

**Summary Sheet, Antenatal Interview**

**LYNNE**

**Summary of information**

Reasons for choosing midwfery led care in birth cente

- Proximity – lives nearby
- Convenience, especially with other child – welcomes ideas of open visiting, and child able to spend plenty of time getting to know new baby, whilst being with mum
- Visited birth centre before making final decision for care – liked friendly atmosphere
- Fancies idea of a waterbirth – keen to try this, has discussed with midwife after watching TV programmes and looking on internet for information.

Previous pregnancy

In DGH – this was first choice this time, until given information about other choices available

Family support for care

Yes – husband likes unit.

Midwifery care

Had excellent one to one relationship with named midwife – felt very supported during pregnancy.

Majority of care given by named midwife.

Felt comfortable to ask questions, and also was confident in other midwives in unit – was able to ring at any time if had a problem or needed advice.

> "I always felt that the midwives had time to answer my questions,
> no matter how trivial they seemed to be"

**Appendix 15**

**Example of Postnatal Interview Transcript**

**Alison 14.4.05 Labour Transfer**
**Postnatal Interview**

**L**
*Would you like to tell me what happened?*

**ALISON**
Oh, What happened! It started Sunday night, probably about 7 o'clock I started having contractions, so we'd had some in the afternoon but they hadn't come to anything, so about 7 o'clock they started coming quite regular, so we started writing them down, whatever, about half past nine they were definitely coming stronger, so I thought I'd try and get a nap, so I went to bed for a bit, and put the TENS machine on. I mean, I was fine, but my husband was like "lets go, lets go!" so about ½ past 2 we did go down. Now earlier that day I'd been down for a sweep 'cos I was late, so this was my second sweep, and (MW) said you're a bout 3 cm, so something is obviously happening, but you're not getting any real contractions or pains or anything yet, so obviously I'd been in labour from about 7 to 3 o'clock, when she examined me, and I was still 3 cm, so she said "oh, get up and walk around", so I was fine, in the room, with the TENS machine on, on my feet the whole time, and when the next shift came on, when they changed over I was examined again, about 8 o'clock in the morning, and I was 3 cm again, and I'd been through really quite strong, frequent contractions, and she (MW) said, really something should have been happening by now, so when she examined me again, she said that the baby was a bit high, so she would 'phone the registrar in Merthyr, and see what they wanted to do. So they phoned, and he said we'd have to go over to PCH. By then the contractions were getting really quite sore, so they put me on gas and air, cos I had a good hour's wait for the ambulance to come and get me. It was the longest wait for anything, and that was fine, so I got to the hospital, and then they examined me about, well they put me on the monitor, she (baby) was fine, so they examined me and I was 5 cm, so

by then we thought well maybe something is happening after all, so they said "keep on your feet as she's still high up, try and bring her down", so I was squatting and rocking and they kept me going to the toilet, a few hours later they checked me again and I was 8 cm, but she was still high up and in the end, it was about 7 o'clock that evening so It's been going about 24 hours, still only on gas and air and the TENS machine, I was coping with it fine, but she wasn't coming down, and I was 10 cm gone, but I had an anterior lip that wasn't shifting, so they got the specialist in and he said "baby's happy as Larry but not shifting down at all, she was still 3/5 ths engaged. By then I was absolutely... I was fine but by then my contractions were coming back to back, it's just that I was absolutely exhausted, absolutely exhausted, so... I think I knew even before I left the Birth Centre: she hasn't dropped, I'm already late, you know, I kind of definitely thought I would end up a C Section, but everyone was like, "Oh, were you disappointed?" but I wasn't, you know, we did everything we could, we went through the whole thing, you know, I had my waters broken in the end which was something I didn't really want to do, but nothing was happening...

**L**

**You try everything**

**ALISON**

Yeah, we thought give it a go, but no. They monitored the whole way through and she was not in any distress, just didn't want to come out, so she was 10 days late, so she didn't want to come out. When they pulled her out she had a face like thunder, the midwife's were laughing, she had a right sulk on

**L**

**She looks a fair size, was she a big baby?**

**ALISON**

8lb 13 – I mean I wasn't expecting a small baby cos I'm 5'9" and my husband's 6'2"

**L**

*Maybe that explains it...*

**ALISON**

Yes, she had bruising across her shoulders – they were trying to get me to push but I just didn't feel any pressure, it was all in the wrong place y'know... so that was that – she's a big girl, but not really massive by any standards, she just didn't want to...

**L**

**It was maybe the position she was in**

**ALISON**

Yeah, they were concerned that she was in the wrong position, facing the wrong way, back to back

**L**

*Yeah, OP, that does sometimes affect them moving down then*
*Oh, so you didn't get your water birth*

**ALISON**

No, like I said, I didn't bother with a birth plan 'cos we didn't know how it would be, planning things,

**L**

No, I think when we spoke antenatally you'd considered all eventualities it seemed to me, so

**ALISON**

Yeah, I wasn't disappointed, I think when they 'phoned the registrar, I expected to go straight in for a section, but they let me carry on labouring, y'know, give it

my best shot, and if I'd gone in straight for a section I'd have been wondering if we could have done something else, so I was wasn't disappointed, in the end she just wasn't going to shift

**L**

**Did you feel that you had been involved in all the decisions?**

**ALISON**

Yes, yes I did, it was fine. The Birth centre was great, and the Hospital was great as well, it all was happy in the end, so...

**L**

**Did your mum go in with you?**

**ALISON**

Yes, and my dad as well!! He was in all the time – in the Birth Centre he sat in the waiting room, but there wasn't anywhere else to go in the hospital, so he came in the room with me. I think they found it quite hard going, y'know, watching me, but they didn't want to not be there at the same time.

**L**

**It was nice if that was what you all wanted**

**ALISON**

At first I was a bit conscious, but after a while...

**L**

You get so that you don't care at that point. Ah well, these things happen...

**ALISON**

Exactly, we gave it a go, so I wasn't disappointed really

**L**

Once you get the baby...

**ALISON**

Yes, the ideal was a water birth, but I was totally prepared for the possibility of a section – it happens, and my husband said...
I was getting later and later, and thinking she was getting bigger as I got later, my stomach was getting bigger, we knew she was going to be big anyway

**L**

I know when we spoke antenatally; you said you had a bit of 'white coat syndrome' so how did that...

**ALISON**

Not too bad. When they did my blood pressure I think when I was still in the birth centre, oh no, it was when I first got into the hospital actually 'cos they used one of those automatic things, so I think the first reading was a bit...

**L**

Not surprising...

**ALISON**

So I said try it again and I think it pumped up twice, and in the end they had to use the manual one anyway cos the reading was sky high, but no, it was all right, I had a nice room. The delivery room was on its own, and nicer than I expected, I didn't expect it to be so private, so that was nice, and I had a student midwife who was really nice, and the sister was the other one taking care of me, so they were both great, reassuring.

**L**

You were quite keen on the open visiting policy in the birth centre, so how did this affect you?

**ALISON**

Yes, that was a bit disappointing because my husband had taken a weeks holiday and was kind of sat round here, a bit of a spare part 'cos he could only come at visiting times. We had expected, a couple of friends had had their babies in Abergavenny, and father's are allowed in that hospital all day so he was expecting to be allowed back and forth, and cos my mum and dad were down and my brother, he had to give up visiting times for all these people, so he only got to see us, his shift was between 4 and 6 at night, so... that was a long day.

**L**

**Did you go back to (birth centre) or did you come straight home?**

**ALISON**

(laughs) No they said, the Monday night I had the drain, catheter and everything, which they took out on Tuesday, so the nurse asked if I wanted to go to Aberdare, which I said would be great, as I was expecting to stay in until Friday. She come back later and said I've some bad news, Aberdare is full to the brim, I just laughed, when I went in they hadn't had a baby born for a few days, then they just had a blow out! She said I could go out the next day anyway, so that was fine. It was just typical

Goes on to talk about the baby, feeding sleeping and the like.

**L**

What did your husband think of it then – he was a bit nervous when you were at home...

**ALISON**

Yes, him and my mum had a massive argument on the day – it was just high emotion I think. He was a bit disappointed that he didn't get to cut the cord and nicey things he was looking forward to doing like that, and because it was so late

in the day she was delivered at ¼ to 8, visitors were out by 9, so, the midwife was really nice, and they put us in the recovery room for a while, but I had to go the ward and he had to go home, so it was a bit of a shame like that, he was on a high and had to just go, but other than that he was fine.

**L**

I can see that you've rationalised it all now, but what about at the time when they said you had to go over, how did you feel then?

**ALISON**

Ummm, Oh I think I knew. I think I knew when, I mean if I was 3cm on the Friday and then after labouring all day on the Sunday and having that exam at 3 in the morning and she said I was still 3, I thought well there's something going on, and then I was having such hard contractions when they examined me again at eight I thought I had to be at least 5, and they said I was still 3, and I thought its not happening, nothing's happening, so I'd kind of worked it out already, I knew myself that, at that point I knew I'd have a C Section, even though I carried on for the rest of the day, and they were like " are you alright for another hour, do you want to try another hour?", and I would say yes yes, try and give it a go, but... I did have a bit of an elation when I'd gone in (to PCH) and they'd examined me and I was 5, I thought maybe Its coming along, but I think when, yeah when they said that morning I was still 3, I thought Oh, C Section. That's the way it went.

**L**

**How was the ambulance journey over? Was it horrible?**

**ALISON**

No it was alright by then, they'd just put me on the gas and air, I think I went through the whole night just on the TENS machine, and I think I was so totally concentrating I forgot there was any other kind of pain relief you know, and when I was waiting for the ambulance, it seemed like such a long time since they

phoned the ambulance and they (contractions) were getting quite sore, they actually had to phone the ambulance and tell them to get a move on, and she said "do you want to try gas and air?", and it was brilliant, and the TENS machine, that was brilliant as it was something I was really concentrating on, and as my mum said, I was away with the fairies, I was having these big contractions and I was clicking away at the Tens machine, so I was perfectly OK with that, but the gas and air just seemed to take the edge off it, so ...

**L**

**You did really well if that's all you used**

**ALISON**

Well yes, I was 30 hours, and when they gave me the epidural (prior to the C/S) I had to come off the gas and air, and I was contracting all the time...

Pauses to answer 'phone

And of course I had a contraction just as they were putting in the needle, and the student midwife said "breathe in", and I said I'm having a contraction, and the student's face was a picture, so she just held my hand, and the anaesthetist told me to lean forward so my spine was in the right position, and then it was in, and I was just happy to have it done at that point. I've had operations, so I wasn't too bothered at that point, and my husband's a medical sales rep, so he was just fine, getting into his scrubs, so...

**L**

**He went into theatre with you?**

**ALISON**

Yes, (laughs) he didn't look 'cos I was chatting to him the whole time, the pain had gone and I was having the time to just catch my breath, and I was expecting... I don't know why I was expecting them to say "oh we're just going

to make an incision now" or something like that, and before I knew it, I could hear her crying, I thought crikey, is that it, and then they said it was a girl and we were just so shocked cos everybody had expected it to be a boy, so it was a lovely surprise at the end of the day when they said it was a girl, all the old wives tales saying it would be a boy, so it was a little bonus when they said it was a girl at the end

**L**

So, on the whole, things didn't work out as you'd planned...

**ALISON**

No, the perfect opposite to what I'd planned, but we did kind of say all the way through our pregnancy, oh we're going for this ultra natural water birth, and we were saying oh you'll have a sunroof! you'll be open like a can of sardines, but my friend in Abergavenny, she was the opposite, she was all for having an epidural, she was going to have a girl, and we kind of did a switch, she had natural childbirth, ended up with a boy and I had her C Section, so we had a bit of a laugh about that.

**L**

In labour, things tend to take control of you, but did you feel in control, given that things were happening that you had no control over?

**ALISON**

Yes, I felt that I had choices; they were asking do you want to do this or that. It was my choice to have my waters broken, and they asked if I wanted to get up and that, so the whole time it was very much my choice of what I wanted to do, and I think they tried, I mean obviously they knew I was from the birth centre, and I was trying to avoid taking anything, so they were checking with me what I wanted to do, and they let me go as long as I possibly could until the end when the specialist came in and said "nothings happening, and we need to go to theatre"

**L**

You haven't really got much of a choice at that stage really...

**ALISON**

No, exactly, and by then I'd been labouring for so long, and she was the wrong way round, sitting just too far back,

**L**

I'm sure she's all worth it,

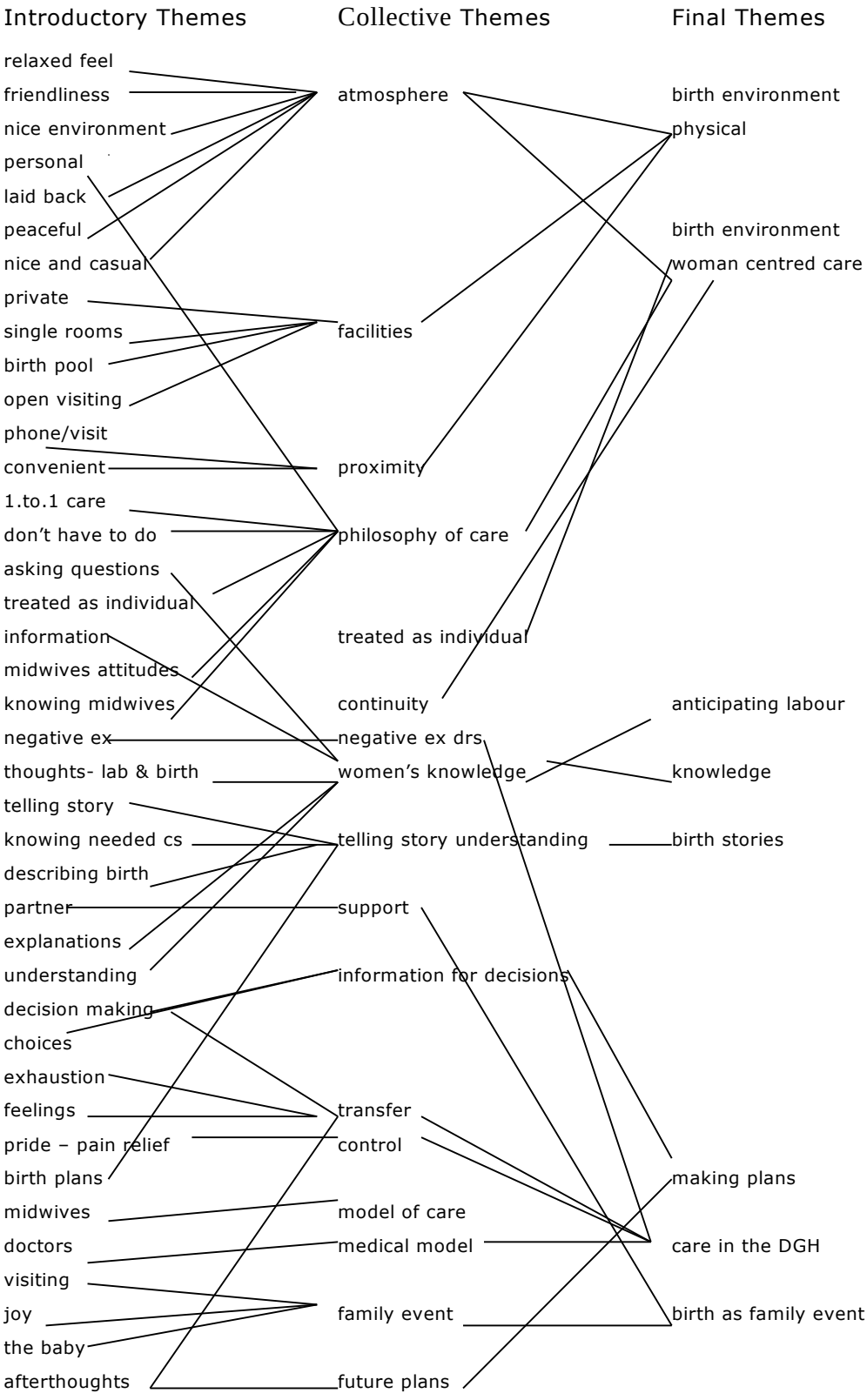
**ALISON**

So far!

Interview draws to a close with general chat about the baby, and problems encountered so far.

**Appendix 16**

**Reduction of Themes**



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